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# THE CULTURE CONNECTION: TESTING A MODEL OF AFRICAN AMERICAN ATTITUDES TOWARD MENTAL HEALTH SERVICE UTILIZATION

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ABSTRACT OF DISSERTATION

Andrea Michelle Smith

The Graduate School

University of Kentucky

2009

THE CULTURE CONNECTION: TESTING A MODEL OF AFRICAN AMERICAN  
ATTITUDES TOWARD MENTAL HEALTH SERVICE UTILIZATION

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ABSTRACT OF DISSERTATION

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A dissertation submitted in partial fulfillment of the  
requirements for the degree of Doctor of Philosophy in the  
College of Arts and Sciences  
at the University of Kentucky

By  
Andrea Michelle Smith

Lexington, Kentucky

Director: Dr. Tamara L. Brown, Associate Professor of Psychology

Lexington, Kentucky

2009

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## ABSTRACT OF DISSERTATION

### THE CULTURE CONNECTION: TESTING A MODEL OF AFRICAN AMERICAN ATTITUDES TOWARD MENTAL HEALTH SERVICE UTILIZATION

The purpose of the current study was to combine the factors previously determined to be related to African American help seeking into a single path model and, using structural equation modeling (SEM), determine the relative influence of each factor in the attitudes toward seeking mental health services (see Figure 2.2) among a community sample of African American adults from several metropolitan areas in the US. As such, SEM was utilized to compare the relative fit of two opposing models within this sample, one where a path from economic barriers to help-seeking attitudes was estimated freely and one where that path was constrained. Many have argued that for African Americans, economic constraints are barriers to seeking help. While existing literature fails to consistently support this contention, the current study does suggest that social status does carry significant weight in predicting attitudes toward seeking mental health services. Acculturation was not as strong of a predictor. Limitations, including the use of an abbreviated help-seeking scale, were discussed. In addition, implications for African Americans seeking services were also discussed.

**KEYWORDS:** Help-seeking, Mental Health, African Americans, SEM, Acculturation

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THE CULTURE CONNECTION: TESTING A MODEL OF AFRICAN AMERICAN  
ATTITUDES TOWARD MENTAL HEALTH SERVICE UTILIZATION

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DISSERTATION

Andrea Michelle Smith

The Graduate School  
University of Kentucky

2009

THE CULTURE CONNECTION: TESTING A MODEL OF AFRICAN AMERICAN  
ATTITUDES TOWARD MENTAL HEALTH SERVICE UTILIZATION

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## ACKNOWLEDGEMENTS

Completing this process has, by far, been the most difficult thing I have ever done in my life. Without question, I could not have come this far alone. First I would like to give all praises to God. There were times when I questioned my ability to finish what I started, but was assured that I can do all things through Christ who strengthens me. Thank you Lord for being my rock and my strength.

I would like to thank my advisor, Tamara L. Brown, for your guidance and wisdom. You've challenged me to be better, and you've made me stronger. I thank you for that. To my advisory committee: Greg Smith, Lynda Brown Wright, David Berry, and Monica Kern- without your insight and technical assistance, this project would not have been successful. To my colleagues, friends, and informal "reviewers" from UK, thank you for your honesty and valuable feedback. David Acevedo, Stephanie Sweatt, Jenny Krietemeyer, Tahirah Abdullah- I would not have made it without your help, and I am forever grateful to you. Hamilton Park United Methodist Church, Plano Community Forum, Links of Lexington/Frankfort, Shiloh Baptist Church, and Betty Goodman (my favorite aunt)- your willingness to help a lowly graduate student in need provided the foundation for my data collection. There would not have been a dissertation without your unselfish participation.

To my family and friends, where do I begin? For your encouragement, your love, and your prayers -- thank you Mom and Dad. To my sister Tracey, I am so glad that you kept me grounded when I struggled to keep it together. Michael, thank you for being my friend and my confidant. You listened even when I didn't feel like talking. Leslie and Ursula- thank you for supporting me, girls. I literally would not have made it without you. And finally to Drs. Chambers and Dennard, faculty advisors from Florida A&M University, you guided me at the beginning of my path and helped see me through to the end.

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## **Chapter One**

### **Review of the Literature**

In any given year, an estimated 22.1% of U.S. adults over the age of 17 suffer from a diagnosable mental disorder (National Institute of Mental Health, 2001) but African Americans are much less likely than other ethnic groups to seek psychological help from a mental health professional for those problems (U.S. Department of Health and Human Services [DHHS], 2001a). This lack of help-seeking is not indicative of a lack of need of mental health services, as 63.6% of over 2,000 African Americans in a national survey reported experiencing serious personal problems (Leong, Wagner, & Tata, 1995). Moreover, African Americans and Caucasians have been shown to have comparable prevalence rates for major depression (9.9% versus 10.0% respectively), panic disorder (1.4% versus 2.2%), and phobic disorder (14.8% versus 15.0%) (Kessler et al., 1994). Despite a lack of disparity between African Americans and Caucasians in terms of mental health problems and despite the fact that one third of Americans with a mental illness or problem receive care, the percentage of African Americans receiving needed care is only half that of non-Hispanic Caucasians (DHHS, 2001a). This occurs largely due to underutilization of services by African Americans. Several factors may lead African Americans to underutilize mental health services including, but not limited to, cost, fragmentation of services, lack of services, and societal stigma toward mental illness (DHHS, 1999). But additional, and arguably more detrimental, barriers deter racial and ethnic minorities: mistrust and fear of treatment, racism, and discrimination, among others. Certainly, these factors have led to African Americans' unfavorable perceptions of mental health treatment (Carten, 2006).

The current study seeks to clarify the relationships among variables that have been correlated with attitudes toward seeking mental health services by previous researchers. First, I discuss historical influences on African Americans' help-seeking attitudes and behaviors. Second, I discuss several existing help-seeking models and critique their effectiveness at explaining the African American help-seeking process. As most extant models are not specific to ethnic minority groups and tend to ignore the effects of culture, I next present a review of the literature on variables that might impact mental health help-seeking for African Americans. Next, based on this review of the

literature, I propose an overarching theoretical model. Finally, I describe this study's test of one aspect of that overarching model.

### *Historical Perspective of African Americans' Attitudes Toward Mental Health Care*

The majority of African Americans in the United States can trace their ancestry to slavery (DHHS, 2001b). Upon their arrival to this country, kidnapped Africans endured horrific acts of inhumanity including physical abuse and extreme psychological distress which continues to ravage their descendents to the present day. Slavery devalued and dehumanized Africans, leaving social, biological and psychological marks on the descendents of all participants in the slave industry (Toppin, 1971). It should come as no surprise then that African Americans are reluctant to receive treatment from a society and system once responsible for their gross mistreatment. Beyond slavery, historical accounts of the experiences of African Americans further reinforce the assumption of the inferiority of African Americans that has dominated common thought of a developing United States. Even the underlying theoretical base for mental health services in this country reveals racist assumptions about the etiology and behavior of African Americans. "Normal" African Americans were described as those who were invariably happy, faithful, and content with their position in life. Labels like "dysaesthesia aethiopica" caused by "insensibility of nerves," "hebetude of mind," and "drapetomania," the mental illness that caused slaves to run away, were utilized to officially diagnose African Americans who were noncompliant and disruptive (Thomas & Sillen, 1979). Such racist labels were instrumental in conveying the message to African Americans that something was wrong with them if they were not satisfied with their station in life. These beliefs have shaped the quality of care provided to the African American mentally ill since the colonial period (Carten, 2006).

Further contributing to African American's historical perceptions of mental health care is the utilization of mental health theories premised in a medical model based in U.S. and Western culture (Carten, 2006). Racist theories continue to inform mental health policy, practice, and research. As late as 1950, articles in medical journals continued to assert African Americans were too mentally uncomplicated to be susceptible to mental illness (Thomas & Sillen, 1979). Such misconceptions and myths about African Americans continue to have residual effects on contemporary mental health services

provided to them. In a literature review chronicling the development of mental health services for African Americans, early forms of care for the mentally ill were shown to be unequal and insufficient (Jackson, 2005). In fact, many southern states developed separate asylums for African Americans in the early 1800's, many of which continued to operate as separate facilities well into the 20<sup>th</sup> century (Jackson, 2005). Due to the clear lack of appropriate treatment and consideration of mental health services for African Americans by the mental health system, their mentally ill were typically looked after by relatives, friends, or other self-help efforts in tightly knit care systems. As a result, African Americans learned to trust themselves and not the mental health care system. This further reinforced the importance of relying on African American traditions and cultural practices for guidance, development, and support, reducing African American's trust of Eurocentric mental health practices.

The historical experiences of African Americans in the U.S. have, indeed, shaped the framework through which African Americans perceive mental health services. Mounting evidence demonstrates that mental health services do not take into account the "uniqueness of the black cultural experience" (Carten, 2006, p. 129). Aspects and behaviors of African American culture have been interpreted by the dominant culture as pathological, mental health care has been unequal in delivery and quality, and existing mental health theory continues to be based on Eurocentric cultural norms.

#### *Existing Conceptual Frameworks of Help-seeking*

A number of frameworks have been utilized to help explain how individuals arrive at a decision to seek help from a mental health professional. Among the more well know frameworks are Anderson's (1995) Behavioral Model of Health Services Use, Pescosolido's (1991) Conceptual Model of Utilization and Compliance, and Cauce and colleagues' (2002) Model of Mental Health Help-Seeking. Given that much has been written in the literature regarding these models, we do not rehash what is already known, but simply focus on where these models overlap in what they tell us about help-seeking.

One of the earliest models of help-seeking was advanced by Anderson in the 1960s, a model he revised in the 1970s and again in 1995 (Anderson, 1995). His Behavioral Model of Health Services Use, designed to be an explanatory and predictive model for utilization of medical services, posits that individuals' decisions to seek



medical help are influenced by exogenous, predisposing factors (demographics, social structure, and health beliefs), enabling resources (personal/family and community), and need (perceived and evaluated). In the model, environmental factors and population-based characteristics influence health and health care behaviors. Essentially, the model suggests that people's use of health services is a function of their predisposition to use services, factors that enable or impede use, and their need for care. Personal health practices and use of health services (along with other factors such as genetics, environmental exposures, and accidental injuries), in turn, determine health outcomes.

A major criticism is that Anderson's model, because it aims to provide an overarching conceptual model, is too broad and nonspecific. Most importantly, for our purposes, the role of cultural context is ignored. While Anderson (1995) argues that cultural factors can fit in the predisposing factor category, his model is really inadequate to explain or predict how the cultures of ethnic minority groups influence their help-seeking as Portes, Kyle and Eaton (1992) make clear in their attempt to apply Anderson's model to Cuban and Haitian immigrants to the U.S. They found that none of the enabling factors in Anderson's model predicted Haitian and Cuban mental health help-seeking. Rather, broad cultural factors neglected by Anderson's model (e.g., nationality, context of exit, facilitational role of the receiving ethnic community, cultural competence of mental health providers, etc.) were the most powerful determinants of mental health service use even after controlling for all individual-level variables. Though it is a seminal model, Anderson's inattention to cultural factors limits the utility of this model for African Americans and other ethnic minorities.

Likewise, Pescosolido (1992) criticized Anderson's model for being too focused on the individual decision-maker and giving insufficient attention to the interactions of persons and environments. It is this dynamic interaction that Pescosolido says cannot adequately be conceptualized as an exogenous factor as Anderson claims. In contrast to Anderson's model, Pescosolido's (1992) Conceptual Model of Utilization and Compliance used a comprehensive "network-episode" – like approach to explain help-seeking as a socially influenced process. She argues that problems (and, thus, help-seeking decisions) are embedded within social networks and that people are embedded within larger cultural structures that form from them and shape them. Her approach shifts

the focus from individual choice to socially constructed patterns of decisions that include consultation with others. Pescosolido (1991) contends that earlier studies examining the use of mental health services have tended to ignore the social processes related to seeking care, but that these processes may be particularly cogent in considering service seeking among African Americans.

While her approach is a helpful extension of Anderson's, moving beyond a solitary individual making a dualistic decision to a consideration of the larger context of decision making episodes, it still does not give adequate attention to cultural forces. To say that cultural context must be factored in is one thing, but to clarify which aspects of culture and to explain how they factor in is quite another. As an example, Rogler and Cortes (1993) illustrate well how the failure to consider how Mexican culture shapes self-reports of physiological symptoms produces measurement error in traditional assessments of psychological distress. Needed is research that moves beyond the general level to focus on particular racial/ethnic groups and to delineate the particular cultural and contextual factors that impinge additively and interactively upon their mental health help-seeking process. It is this level of specificity, which Pescosolido discusses but fails to provide, that is sorely needed if we are to understand and facilitate African American mental health help-seeking.

Cauce and colleagues (2002) developed a model to describe the protracted process of adolescent help-seeking that contains three components: problem recognition, the decision to seek help, and the selection of a help provider. As a first step, problem recognition refers to the realization that some problem exists whether this is a diagnostic label (e.g., depression) or functional impairment (e.g., subjective experience, distress tolerance level). The decision to seek help, the second component of the model, is most likely to occur when a mental health problem is recognized as undesirable and not apt to go away on its own (Cauce et al., 2002). Though it is not clear how, the decision to seek help is likely culturally and contextually influenced, as some cultures believe the best way to deal with problems is not to think about them whereas others believe that to seek outside help is shameful (Cauce et al., 2002). After a problem has been identified and a decision made to seek help, service selection, the third component of the model, refers to where individuals turn for assistance. Far from a straight-forward decision, service

selection depends upon factors such as service availability, eligibility requirements, and service provider cultural competence. Although Cauce et al. emphasize that the effects of culture and context are profound across the entire help-seeking pathway from problem identification to choice of treatment providers, they acknowledge that work in this area is too limited to be specific: “it is still too early to come to firm conclusions about the role of culture in adolescent mental health help seeking” (p. 48). Thus, they point out that their model does not explicitly have a place for culture and context but that culture and context surround all the constructs. This lack of specificity makes it unclear how and where culture fits in. Clearly, there is a need for more explicit demarcation of what factors unique to the African American experience play a role in the help-seeking process.

#### *Barriers to Mental Health Care for African Americans*

A number of studies have demonstrated the link between variables predicted to have relationships with help-seeking among African Americans. However, given the range and scope of these studies and the types of variables investigated, it is difficult to sort out which aspects are important. To help classify the breadth of variables investigated, Swanson and Ward (1995) presented a conceptual framework for differentiating barriers to accessing mental health services into four categories: economic, systemic, individual, and sociocultural (hereafter referred to as simply cultural). The following sections will review and discuss the extant literature for each category of barriers in turn.

*Systemic barriers.* Systemic barriers are factors that affect the accuracy of the assessment and appropriateness of treatment provided to individuals seeking help. More clearly illustrated in the section on historical context, systemic barriers are those that African Americans have watched develop over time. African Americans are deterred from seeking formal mental health services for fear of not receiving equally effective, unbiased, or competent services. Systemic barriers that militate against African Americans’ decisions to seek professional mental health services are cultural incompetence, clinical bias, and over-reliance on medication.

Bias and incompetence. Clinicians reflect the attitudes and discriminatory practices of their society (Whaley, 1998). The consequence is that, in the U.S., clinical

decision making regarding diagnosis, treatment, prescribing medications, and referrals is influenced by racism, discrimination, and stereotypes. For example, research also shows that ethnic minority clients are less likely than whites to receive the best available treatments for depression and anxiety (Wang et al., 2000; Young et al., 2001). Additionally, Jenkins-Hall and Sacco (1991) found that white therapists rated a videotape of an African American client with depression more negatively than they did a white patient with identical symptoms, and Bond, DiCandia, and MacKinnon (1988) found that African American youth were four times more likely than white youth to be physically restrained after acting in similarly aggressive ways. The persistence of diagnostic bias in treating African American clients (Snowden, 2003) has led to them being assigned more severe psychiatric diagnoses than are warranted, being overdiagnosed for schizophrenia, and being underdiagnosed for affective disorders (Baker & Bell, 1999; Snowden & Cheung, 1990; Trierweiler et al., 2000; Neighbors, Jackson, Campbell, & Williams, 1989), problems that have resulted in improper treatment for African Americans in need of mental health care.

Recognition of the inadequate mental health care afforded ethnic minorities has led many to advocate for a new treatment approach, one that delivers services in accord with the cultural concerns and experiences of racial and ethnic minority groups including their languages, histories, traditions, beliefs, and values (DHHS, 2001b). This approach to service delivery, which places the responsibility on mental health service organizations and practitioners – most of whom are white – for delivering culturally appropriate services, is referred to as cultural competence and is predicated on the conviction that services tailored to culture would be more inviting and more effective (Carten, 2006; DHHS, 2001b). The fact that most mental health providers are white means that, for African Americans seeking services the most likely clinical scenario is a cross-cultural, client-therapist dyad. As opportunities for cultural misunderstanding that lead to ineffective and inappropriate mental health care are increased in cross-cultural client-therapist dyads, the need for cultural competence in mental health care is critical. Thus, clinician bias and cultural incompetence create systemic barriers to African American service utilization. That most mental health providers have received little, if any, diversity and cultural competence training only exacerbates an already problematic

situation, placing African American clients at increased risk of being victims of clinician bias and incompetence. Because greater potential for the cultural misunderstandings that lead to racism, disrespect, bias, and misdiagnosis occur when clinicians and clients do not come from the same cultural background (Hunt, 1995; Porter, 1997), some researchers have suggested that matching clients and therapists on race and/or ethnicity and using ethnic-specific interventions might decrease bias and incompetence thereby improving the experiences African Americans have when seeking professional mental health services (Barkley, 2000; Jerrell, 1998; Krauss, Goldsamt, Bula, & Sember, 1997; McKay et al., 2002; Snowden, 1998a; Sue, 1977; Sue & Sue, 1999; Snowden et al., 1995). Findings from ethnic matching studies suggest that when African Americans were matched with a same-race service provider, those services were more effective. Atkinson (1983) and Atkinson and colleagues (1986) demonstrated that ethnic match of the service provider is an important determinant for African Americans seeking mental health services. Reviews of this line of research (Atkinson, 1983) have consistently concluded that the data supporting the superiority of ethnically or racially similar counseling dyads are equivocal. In Atkinson and colleagues' (1986) study, a sample of 128 black community college students deemed ethnicity similarity as a significant counselor characteristic. Additionally, African American's preference for a racially similar counselor has been documented for elementary school children, their parents, or both (Pinchot, Riccio, & Peters, 1975), high school seniors (Riccio & Barnes, 1973), and Veterans Administration outpatients (Proctor & Rosen, 1981). However, the low number of available African American mental health providers makes ethnic matching an impotent strategy for eradicating this systemic barrier to service utilization for the vast numbers of African Americans needing mental health care.

Over-reliance on medication. Clinicians in psychiatric emergency services (Segel et al., 1996) and other inpatient service settings (Chung et al., 1995) prescribe both more and higher doses of oral and injectable antipsychotic medications to African Americans than to whites. African Americans are also more likely to receive higher overall doses of neuroleptics than are whites (Marcolin, 1991; Segel et al., 1996; Walkup et al., 2000). This overmedication of antipsychotic drugs (combined with their slow metabolism rate (Bradford, Gaedigk, & Leeder, 1998) yields a variety of extra-pyramidal side effects

including stiffness, jitteriness, muscle cramps (Lin et al., 1997) and increased risk of long-term severe side effects such as tardive dyskinesia, a condition that is more prevalent in African Americans than whites (Glazer, Morgenstern, & Coucette, 1994; Jeste, Lindamer, Evans, & Lacro, 1996; Morgenstern & Glazer, 1993). This disparity in the quality of pharmacological care African Americans receive (Burroughs et al., 2002) and the more toxic side effects they experience compared to whites (Strickland et al., 1991) have contributed to African Americans' negative attitudes toward mental health services.

Given the over-reliance on medication with African American clients, the fact that medication therapy is increasingly a critical component of mental health treatment creates barrier to service utilization by African Americans who, generally speaking, tend to prefer the use of nonmedical measures and counseling over drug therapy (Croghan et al., 2003; Dwight-Johnson et al., 2000) due to their concerns about side effects, effectiveness, and addiction potential of medication (Cooper-Patrick et al., 1997). Though the newer SSRI medications tend to have fewer side effects, they are less often prescribed to African Americans than to Caucasians (DHHS, 2001b). Thus, the increased and inappropriate use of psychotropic measures for treating mental illness has become an additional deterrent for African Americans seeking help.

*Individual barriers.* Individual barriers are those factors that include characteristics germane to individual persons, those the idiosyncrasies that make certain African Americans more or less likely to seek help from a professional mental health provider. Individual barriers are not attributable to culture, economics, or systemic barriers and include age, gender, perception of bias and cultural incompetence, symptom severity, perception of distress, and the nature of the problem experienced.

Age. Regardless of race or ethnicity, mental health care utilization patterns vary by age. In general, 26 to 49 year olds are more likely to seek psychological services when faced with difficulties than younger or older adults (Barker et al., 2004). However, the connection between age and service use is not so clear among African Americans. Whereas Duncan (2003) found that African American college students have more positive attitudes about seeking psychological help, Neighbors (1991) found that 18 to 24 year old African Americans are less likely to seek help than older African Americans.

Parham, White, and Ajamu (1999) report that older African American men are over-represented in mental hospitals, a finding that suggests that being older (and male) is associated with increased mental health service use for African Americans. However, the fact that Parham, White and Ajamu (1999) confounded age and social class makes it impossible to know if this is really an age effect or an SES effect. Overall, findings regarding the link between age and mental health help-seeking among African Americans are inconsistent. While some studies indicate that older African Americans tend to have more positive attitudes toward seeking psychological help, others contradict this finding. Moreover, the age groups studied are not comparable across studies, making it difficult to draw definitive conclusions regarding age. Further investigation is warranted to help explain the role of age in the African American help-seeking process.

Gender. In general, differences in help-seeking attitudes vary by gender. Research indicates that females generally have more positive help-seeking attitudes and are more likely to seek counseling services than males (Fischer & Farina, 1995; Fischer & Turner, 1970; Leong & Zachar, 1999). However, it is unclear whether these gender differences apply to African Americans. Very little is known about how male and female African Americans differ in the help-seeking process (Sheu & Sedlacek, 2004). Neighbors and Howard (1987) conducted one of the few studies on this topic and found that African American women are more likely to seek professional help than African American men. However, it is difficult to know how to interpret this finding or to know the magnitude of the difference.

This gender difference may be an artifact of the fact that much less research has been conducted on African American men (Lee & Bailey, 1997). Thus, it is possible that African American women seek services at the same low rate as African American men but male help-seeking patterns are not captured due to the way studies are designed. Or, the gender difference may be real but reflect socialization differences. For example, Block (1981) suggests that African American men do not voluntarily seek mental health services because they are socialized to handle problems by not showing stress or suppressing the intensity of the stress. This seems less likely to explain many gender differences because African American women are socialized similarly. Research shows that African American women tend not to seek services until a crisis has been reached

(Mays et al., 1996). Thus, though women seem more likely to utilize services the difference may not be very meaningful as both African American men and women tend to delay seeking (and underutilize) mental health care. Alternatively, according to Franklin (1992), African American men's socialization dictates that men should never drop their defenses with Caucasian people. As most mental health professionals are Caucasian, the lack of service use by African American men may be less about their willingness to seek professional help and more about a lack of culturally acceptable mental health care providers.

Perception of bias and cultural incompetence. Regardless of what bias may or may not exist in the diagnosis, assessment, and treatment of African Americans, many African Americans perceive that mental health services are biased unfairly against them. A survey conducted for the Kaiser Family Foundation (Brown et al., 1999) found that 12% of African Americans, in comparison with 1% of Caucasians, felt that a doctor or health provider judged them unfairly or treated them with disrespect because of their race or ethnic background. Even more compelling, the Commonwealth Fund Minority Health Survey found that 43% of African Americans in comparison with 5% of Caucasians felt that a health care provider treated them badly because of their race or ethnic background (LaVeist et al., 2000). These differences have aroused suspicion that clinicians are biased in the course of routine clinical practice, and that practitioners and mental health program administrators make unwarranted judgments about people on the basis of race or ethnicity. Whether African Americans' perceptions of bias are direct effects (i.e., individuals are knowledgeable about specific events and make choices in reaction to this knowledge) or indirect effects (i.e., a bias exists that is grounded in past events and has been inter-generationally communicated to individuals in a way that influences their choices today), they powerfully influence their help-seeking attitudes and behaviors.

Many African Americans perceive mental health services to be biased because they tend to view White counselors as less culturally competent and less credible sources of help (Duncan, 2005). Indeed, the primary reasons African Americans and other ethnic minority members do not seek psychological treatment are their feelings that their cultural and ethnic background is not understood (e.g., Kinzie et al., 1988), the perception that existing services are unresponsive and insensitive to their needs (e.g., Barter &



Barter, 1974), and lack of trust in mainstream health providers (Kinzie et al., 1988). In short, African Americans perceive mental health providers to be culturally incompetent, and because of this perception, they do not believe professional mental health services will be helpful. Underlying cultural competence is the conviction that services tailored to culture are more inviting, encourage ethnic minorities to get treatment, and improve their outcome once in treatment. Specifically, the term competence places the responsibility on mental health services organizations and practitioners – most of whom are Caucasian (Peterson et al., 1996) – and challenges them to deliver culturally appropriate services.

The lack of African American mental health care providers is notable and may affect perceptions of cultural competence in mental health treatment. While recent data reveal that African Americans represent 12.9% of the United States population and comprise the second largest racial minority group in the U.S. (U.S. Census Bureau, 2005), they represent only 1.7 % of licensed psychologists, 2% of psychiatrists, 3.1 % of licensed professional counselors, and 4% of social workers (DHHS, 2001b). The low number of African American mental health providers is significant because research shows that clients who have therapists that are of the same ethnic group are more likely to seek psychological help, feel more comfortable with their therapist, and are more likely to perceive the therapist understands their concerns (Copeland, 2006). Some researchers suggest ethnic matching of client and therapist and the use of ethnic-specific services influence the perceptions African Americans have of the overall mental health service delivery system (Barkley, 2000; Jerrell, 1998; Krauss, Goldsamt, Bula, & Sember, 1997; McKay et al., 2002; Snowden, 1998a; Sue, 1997; Sue & Sue, 1999). Clearly, an individual's perception of how he or she is treated by the mental health care system, of how fair the system is, and of whether the provider understands him or her, are all important individual factors to consider in the help-seeking pathway.

Distress level. Symptom severity predicts help-seeking among African Americans. Sussman, Robins, and Earls (1987) examined data from a psychiatric, epidemiologic survey of African Americans and found number of symptoms during the worst episode and the duration of the longest episode are related to treatment seeking; those who did not seek services had fewer symptoms in a single episode, experienced fewer episodes, and did not have prolonged episodes. Neighbors (1984) examined

professional help use among African Americans and, arguing that the lay person's perspective on the nature of his or her distress should be considered in explaining utilization behavior, found that experiencing a personal problem at the "nervous breakdown level" significantly increases the likelihood of seeking professional help. Tomlinson and Cope (1988) found that African American students who sought help from the counseling center rated their problems as "marked" or "extreme" in severity, supporting the argument that African Americans are more likely to seek help when symptoms become severe or intolerable. Constantine, Wilton, and Caldwell (2003), in their investigation of psychological distress and African American students' willingness to seek psychological help, found that African American students who reported higher levels of psychological distress were more willing to seek mental health counseling currently or in the near future than were those with lower levels of distress. Overall, findings consistently indicate that African Americans who report fewer or less severe symptoms are less likely to seek professional help, while those who experience higher levels of distress are more likely to seek help from a mental health professional.

Nature of distress. Whether African Americans seek help from mental health professionals also depends, in part, upon the nature of the problem. African Americans have more positive attitudes toward seeking help for impersonal issues such as study skills, time management, educational/vocational issues, and problems with law and social welfare services (Hill & Sedlacek, 1995; Wood & Sherrets, 1984). However, when it comes to personal problems such as assertiveness, self-esteem, and relationship concerns, African Americans tend to prefer to use personal sources of help such as friends, family members, and religious leaders (Sheu & Sedlacek, 2004; Sue, Zane & Young, 1994). Variables contributing to this impersonalization may include African Americans' distrust of mental health professionals and institutions (Terrell & Terrell, 1981; 1984) and the dissimilarity in ethnicity, attitudes, and values between African American clients and their therapists, who are primarily Caucasian (Atkinson, 1983; Atkinson et al., 1986).

*Economic barriers.* Also of concern are the economic or financial barriers that impede African Americans' access to quality mental health care. Economic barriers are those, frequently based on SES, that limit African Americans' access and availability of care. With African Americans being overrepresented among low income groups (i.e.,

22% of African American families fall below poverty), they often have less access to health insurance, have a greater reliance on public mental health systems, and often face difficulties obtaining high-quality care from well trained clinicians (Swanson & Ward, 1995; U.S. Census Bureau, 2005). Yet, the emphasis placed on economic barriers as an explanation for African Americans' low mental health service utilization may be greatly overstated, as the empirical evidence to support a strong link is limited and mixed. There is more evidence to suggest a link between SES and mental health functioning among African Americans than between SES and decisions to seek services from mental health professionals.

SES is linked to mental health. Poor mental health is more common among those who are impoverished than among those who are more affluent (DHHS, 2001b). Moreover, Williams, Takeuchi, and Adair (1992) report that SES variations within racial groups are predictive of mental well-being. Also related to SES is the increased likelihood of African Americans becoming members of high-need populations, such as people who are homeless, incarcerated, or have substance abuse problems, and children who come to the attention of child welfare authorities and are placed in foster care (DHHS, 2001b). Although SES is an important predictor of mental health functioning (Duncan, 2003), how it influences professional mental health services utilization is unclear, as findings regarding the relationship between SES and service use have been inconsistent. Neighbors (1991) examined the usage of human services by 631 African Americans based on problem severity and income and found that low-income African Americans were 1.5 times more likely to utilize human services (e.g., community mental health centers, private mental health therapists, etc.) than high-income African Americans, regardless of the problem type. In contrast, other researchers report that when potential African American clients experience emotional problems, education and income do not differentiate between those who frequented mental health facilities and those who do not (Baker, 1977; Tischler, Heinsz, Myers, & Boswell, 1975). The contradiction in findings between SES and utilization of services by African Americans has highlighted the difficulty in separating utilization patterns based on race as opposed to utilization patterns based on SES (Kessler & Neighbors, 1986; Williams & Collins, 1995).

While it seems clear that economic factors play a role in overall mental health, it

is not clear, from the available evidence, that economic factors determine which African Americans will use mental health services and which will not. Moreover, I am not aware of any model that explains how and under what circumstances economic factors differentiate among African Americans in their help-seeking attitudes and behaviors. In fact, research seems suggest that African Americans have similar attitudes and behaviors toward mental health care regardless of social status.

In 1973, Wolkon and colleagues, in their investigation of race and social class as factors in the orientation toward psychotherapy found that middle class African Americans were more similar to lower class African Americans than to middle class Caucasians, indicating that willingness to seek professional mental health services is more associated with race socialization than with class socialization. Additionally, lack of health insurance has been asserted as a financial barrier preventing African Americans from seeking and utilizing mental health care. Nearly one-fourth of African Americans are uninsured (Brown et al., 2000), a percentage 1.5 times greater than the Caucasian rate. In the United States, health insurance is typically provided as an employment benefit. However, because African Americans are more often employed in marginal jobs, the rate of employer-based coverage among employed African Americans is substantially lower than the rate among employed Caucasians (53% versus 73%; Hall et al., 1999). However, research shows that having insurance with generous mental health coverage does not necessarily increase treatment seeking among African Americans. Padgett, Struening, Andrews, and Pittman (1995) found that while Caucasians with more generous mental health coverage were more likely to make an outpatient mental health visit than Caucasians with less general coverage, this pattern of behavior did not hold for African Americans. Clearly, insurance alone fails to eliminate disparities in access between African Americans and Caucasians (Scheffler & Miller, 1989; Snowden & Thomas, 2000), as African American service use is less responsive to financial means than is Caucasian service use.

Overcoming financial barriers is an important step in eliminating disparities in care, though it is not, in itself, sufficient. While economic concerns may limit the quality, quantity, and type of mental health care that is available to African Americans, they do not seem to be able to differentiate among African Americans in their decisions to seek

professional mental health care. Even when African Americans can afford mental health services and/or have insurance coverage for mental health care, they still utilize mental health services at the same low rate. Thus, I argue that help-seeking among African Americans cannot be accounted for or explained by economic barriers alone, and perhaps not at all. Economic barriers likely play a distal role, at best, in explaining African American use of mental health services and may not be predictive at all when other, more proximal, factors are considered. Factors I believe are more proximal, and thus more powerful, determinants of help-seeking include cultural barriers. I discuss these next.

*Cultural barriers.* Culture, broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999), plays a pivotal role in mental health, mental illness, and mental health services. Understanding culture enables the mental health field to design and deliver services that are more responsive to the needs of racial and ethnic minorities (DHHS, 2001b). Cultural beliefs are key deciding factors in whether people seek help in the first place, what types of help they seek, what coping styles they have, and how much stigma they attach to mental illness (DHHS, 2001b). While cultural and social contexts are not the only determinants, they do shape the mental health of ethnic minorities and alter the types of mental health services they use. While we have evidence about how distinct variables impact the help-seeking attitudes and behaviors of African Americans, we have yet to fully conceptualize how those variables work together to either facilitate or impede the path towards mental health service utilization.

Of special interest in the current study are the cultural barriers to accessing mental health services, those components of an individual's cultural experience that prevent or inhibit him or her from seeking treatment from a mental health provider. These include, but are not limited to, history of experiences with racism and discrimination which contribute to fear and mistrust of formal systems; stigma associated with mental health services that contributes to feelings of embarrassment, shame, and an unwillingness to discuss problems with professionals; belief systems anchored in spirituality; the perceived importance of cultural identification; and the tradition of utilizing more informal means of help rather than psychological services.

Fear and mistrust. Fear and mistrust of clinicians by African Americans, identified by the Surgeon General as major barriers to the receipt of mental health

treatment by racial and ethnic minorities (DHHS, 1999), arises, largely, from historical persecution and from present-day struggles with racism and discrimination and indifference and disrespect exhibited by some health care professionals toward people of color and people who are socioeconomically disadvantaged (Swanson & Ward, 1995). A number of historical events have helped solidify this mistrust including the Tuskegee Experiment (Jones, 1993) and more recent occurrences like the 1992 Columbia University study looking for a genetic link to violent behavior that only recruited young black boys from poor neighborhoods. In this study, researchers misled parents, claiming their children were simply coming in for a series of tests and questions, when in fact they were given potentially risky doses of the same drug found in the Fen-Pfen weight loss pill (Washington, 2007). Centuries of documented (and undocumented) abuses and mistreatment, both in the past and more recently, by medical and mental health professionals (Neal-Barnett & Smith, 1997; Washington, 2007) have led to fear and mistrust, which, in turn, significantly predicts low service use among African Americans (Cooper-Patrick et al., 1999). According to findings from the Epidemiologic Catchment Area study, almost half of African Americans, as opposed to 20% of Caucasians, report being afraid of mental health treatment and cite their fears of hospitalization and treatment as reasons for not seeking mental health treatment (Sussman et al., 1987).

Cultural mistrust, the degree to which African Americans mistrust Caucasians (Terrell & Terrell, 1981; Watkins et al., 1989), is a specific form of mistrust that may have a particularly negative impact on African Americans' help-seeking behaviors, especially in settings where they are unlikely to be treated by an African American mental health professional. Greater cultural mistrust is associated with unwillingness to self-disclose (Poston, Craine, & Atkinson, 1991) and greater expectations that help from counselors will be ineffectual (Nickerson, Helms, & Terrell, 1994). Whaley (2001) conducted a meta-analysis to ascertain the relationship between cultural mistrust and psychosocial domains that included attitudes and behaviors toward mental health service use. He found a medium effect size (average  $r = .34$ ) for the relationship between cultural mistrust and attitudes related to mental health service use across nine studies that employed the Cultural Mistrust Inventory (Terrell & Terrell, 1981), the most utilized measure for assessing cultural mistrust in African Americans. In sum, fear of treatment,

cultural mistrust, and mistrust of the mental health system in general, are consistent and powerful predictors of help-seeking attitudes among African Americans.

Stigma and shame. An equally significant barrier to mental health services, stigma was portrayed by the Surgeon General as the “most formidable obstacle to future progress in the arena of mental illness and health” (DHHS, 2001b, p. 29). Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn, 1999). Stigma is a widespread problem in the United States (Brockington et al., 1993), causing individuals with mental problems to internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment (Sussman et al., 1987; Wahl, 1999). Similar to other ethnic groups, mental illness retains considerable stigma within the African American community, and this stigma influences service utilization patterns (Link & Phelan, 1999; Markowitz, 1998; Sirey et al., 2001). However, African American patients raise more concerns regarding stigma than Caucasian patients (Cooper-Patrick et al., 1997), and express more negative attitudes toward individuals with mental illness than members of other ethnic groups (Silva de Crane & Spielberger, 1981). The threat or perception of social rejection, diminished self-esteem, and lack of family support may account for underutilization of services (DHHS, 2001b). Whaley (1997), in a nationally representative study, sought to reduce stigma against mental illness by exposing various ethnic groups to individuals with mental illness. However, while exposure to individuals with mental illness helped to reduce stigma for Caucasians, it did not for African Americans. Though stigma seems to deter major segments of the population, Caucasians and people of color alike, from seeking help, Whaley (1997) suggests that African Americans hold stronger stigmatizing attitudes toward mental illness than do Caucasians.

Religiosity/Spirituality. Religion and spirituality have historically played significant roles in the lives of African Americans (Taylor & Chatters, 1988) and served as important components of their self-esteem and psychological health (Edwards, 1987; Krause & Van Tran, 1989). The “Black Church” has had a history of being the only institution that African Americans could rely on to meet their emotional, material, psychological, social, and spiritual needs (Barbarin, 1983; Taylor & Chatters, 1988) and

has become a major coping resource in the African American community (Boyd-Franklin, 1989; Dressler, 1991). Moreover, religious leaders in the church have become key sources of help when African Americans face emotional or psychological concerns as an alternative to professional mental health services. As African American ministers are firmly embedded within African American neighborhoods in a way that mental health professionals may never be, they make significant contributions to community mental health by serving such roles as family counselor, diagnostician, therapist, and referral agent (Levin, 1984). As such, they are almost as accessible (psychologically and physically) as most family and friends. Yet, they have a level of respect, influence, and responsibility that distinguishes them from other informal helpers by virtue of the fact that they are located within an organization (i.e., the church) that is clearly viewed as a source of comfort and support (Taylor & Chatters, 1986; 1988). Although ministers are limited in expertise regarding how to address psychological concerns, they tend to be one of the first sources of help contacted by African Americans in psychological distress, and those who contact clergy first are less likely to seek help from mental health professionals (Neighbors et al., 1998). More than any other influence on the help-seeking behaviors of African Americans, religious leaders, and the church in general, hold the most potential for opening a wider pathway between the African American community and mental health care (Neighbors et al., 1998) because seeking help from religious leaders eliminates one of the most difficult barriers African Americans face when considering mental health care, the stigma attached to the possibility of being labeled “crazy.”

Cultural identification. By cultural identification we mean the cultural group with which an individual identifies and the magnitude or salience of that identification. Cultural identification has typically been operationalized in one of two ways: racial/ethnic identity and acculturation. Both may be predictive of mental health care utilization for African Americans

Ethnic identity, an enduring fundamental aspect of the self that includes a sense of membership in an ethnic group and the attitudes and feelings associated with that membership (Phinney, 1996), is one of the most prominent variables in research involving US ethnic groups (Greig, 2003) and is most predictive of what constitutes a sense of self in African Americans (Aries & Moorehead, 1989). Austin, Carter, and Vaux



(1990) examined whether racial identity [measured using the Racial Identity Attitude Scale (Parham & Helms, 1981)] contributed to African American students' attitudes toward counseling and counseling centers. They found that pre-encounter attitudes (the stage in which an individual assimilates himself or herself into the Caucasian standard and holds anti-African American and pro-European American beliefs) were positively related to the perception that counseling is an effective means of problem resolution. The opposite was true for those espousing an internalization point of view (the stage in which an individual achieves an African American worldview and a sense of inner security and self-confidence with his or her Blackness). Unfortunately, other studies of the impact of racial identity on the help-seeking process are too fraught with methodological problems to be helpful. For example, Bonner (1997) concluded that black students stay away from college counseling centers because they do not expect to find counselors who would understand and identify with their problems. However, rather than use established measures, he used disparate and invalidated inventories, and did not report the correlation coefficient between racial identity and help-seeking attitudes, making it impossible to know whether a significant relationship between these constructs exists. Thus, what we know about ethnic/racial identity's role in the help-seeking process for African Americans is limited.

Acculturation comprises those changes in a culture brought about by another culture and which result in increased similarity between the two cultures (Kroeber, 1948). Though this type of change may be reciprocal, typically this process is asymmetrical with one culture changing more than the other; the result is the gradual, and usually partial, incorporation of one culture into another. Very few studies directly measure African American acculturation, and none have investigated its relation to psychological help-seeking. One study, investigating help-seeking behaviors for intimate partner violence (Lipsky, Caetano, Field, & Larkin, 2006), found that greater adherence to practices and norms of one's ethnic group of origin was associated with decreased utilization of social services for Latinas. Although African Americans were included in this study, Lipsky et al. (2006) only assessed acculturation in the Latina subsample. I would speculate that acculturation would function similarly for African Americans, but, to date, this has not been investigated.

While there is a dearth of literature investigating the role of cultural identification in help-seeking attitudes and behaviors among African Americans, the gap in the literature seems particularly wide regarding African American acculturation. The scant research we do have available seems to suggest that being more strongly identified with African American culture is related to unfavorable attitudes toward professional mental health services, whereas African Americans who are strongly identified with Caucasian culture have favorable attitudes toward professional counseling to solve problems. Clearly, additional empirical evidence is needed to clarify the connection between cultural identification and help-seeking among African Americans and to fill the gap in the acculturation literature.

Self reliance and use of informal networks. Another barrier to utilization of formal mental health services is the African American tradition of self-reliance. Historically excluded from participation in public and private social welfare programs or relegated to segregated programs of lower quality (Carten, 2006), African Americans have learned to look to family, friends, church, and other informal helpers before turning to formal mental health systems (Jones & Gray, 1986; Neighbors, 1985). In their classic paper on the use of informal and formal help, Neighbors and Jackson (1984) utilized data from the National Survey of Black Americans to analyze four patterns of help-seeking: informal help only, formal help only, both informal and formal help, and no help-seeking at all. They found that about 87% of participants endorsed utilization of informal help only or conjointly with formal help, whereas about 49% sought professional help exclusively. Only about 4% entered directly into professional treatment without first seeking informal help while about 9% of those considered to have a serious problem sought no form of help whatsoever. Although use of informal help is well supported, African Americans seem reluctant to seek formal mental health services. This tendency to use informal help sources occurs regardless of problem severity (Jackson & Wolford, 1992). In contrast to Neighbors and Jackson (1984), Snowden (1998b) found that African Americans often turn to informal helpers in conjunction with formal helpers, a pattern he describes as “help-seeking facilitation.” Essentially, informal helpers act as a referral source, paving the way to professional intervention. While findings are somewhat contradictory, indicating that more research is needed to understand its role in the help-

seeking process, they suggest that African Americans' self-reliance and dependence on an informal help network can be a barrier to professional mental health service use.

### *Testing a Model of Help-seeking for African Americans*

Decisions to seek professional mental health services are largely determined by one's attitudes toward professional mental health (Ajzen & Fishbein, 1980). In other words, people are unlikely to decide to seek services if their attitudes and beliefs about those services are negative or unfavorable. Thus, attitudes toward seeking professional mental health services are pivotal and were the focus of this study. My intent was to examine how the various categories of barriers reviewed in this chapter influence African Americans' attitudes toward mental health services. Conceptually, this is depicted in Figure 1.1.

However, for practical reasons, I did not include systemic barriers in this study. As I have argued, systemic barriers powerfully influence help seeking attitudes. However, systemic barriers are difficult to capture because they are artifacts of modern society and the manner in which mental health services operate in the US. Moreover, the methodology used in this study relied on self-assessment measures, a measurement approach that is inadequate for assessing systemic constructs. While capturing the macro-level influence of systemic barriers to mental health service utilization is critical, it was beyond the scope of the current investigation.

The key issue for this study was investigating the relative role of economic factors versus cultural factors in predicting attitudes toward mental health services. The argument I have made in this chapter is that cultural factors will more powerfully influence help-seeking than will economic factors and, further, that economic factors will not influence help-seeking at all once the effects of cultural factors are factors in. While the literature on the role of cultural factors has been strong and consistent, research on the role of economic factors has been inconsistent with several studies arguing convincingly that economic factors do not differentiate between African Americans who seek services and those who do not. Thus, the aim of this study was to test this assertion directly. In order to focus most clearly on this comparison between cultural and economic barriers, individual barriers were also not included in this study. Thus, while Figure 1.1 represents the conceptual model that follows from the literature reviewed in this chapter, Figure 1.2

more accurately captures the component of that overarching model that was tested in this study.

As can be seen in Figure 1.2, economic and cultural factors are depicted as latent variables and each of the variables reviewed in this chapter is depicted as their indicator variables. Notice also that the path from cultural barriers to attitudes toward mental health services was freely estimated (as indicated by the asterisk) whereas the path from economic barriers was constrained to zero. Constraining the economic path to zero provides the comparative test that was the focus of this study. The zero indicates my hypothesis that economic factors would be unsuccessful in differentiating the help-seeking attitudes of African Americans in this study.

Figure 1.1

Conceptual Model of Barriers that Influence African Americans' Attitudes toward Mental Health Services

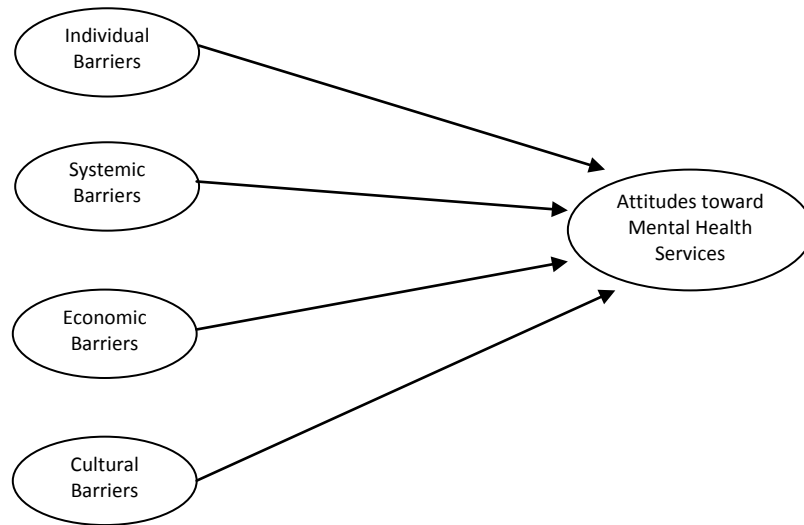
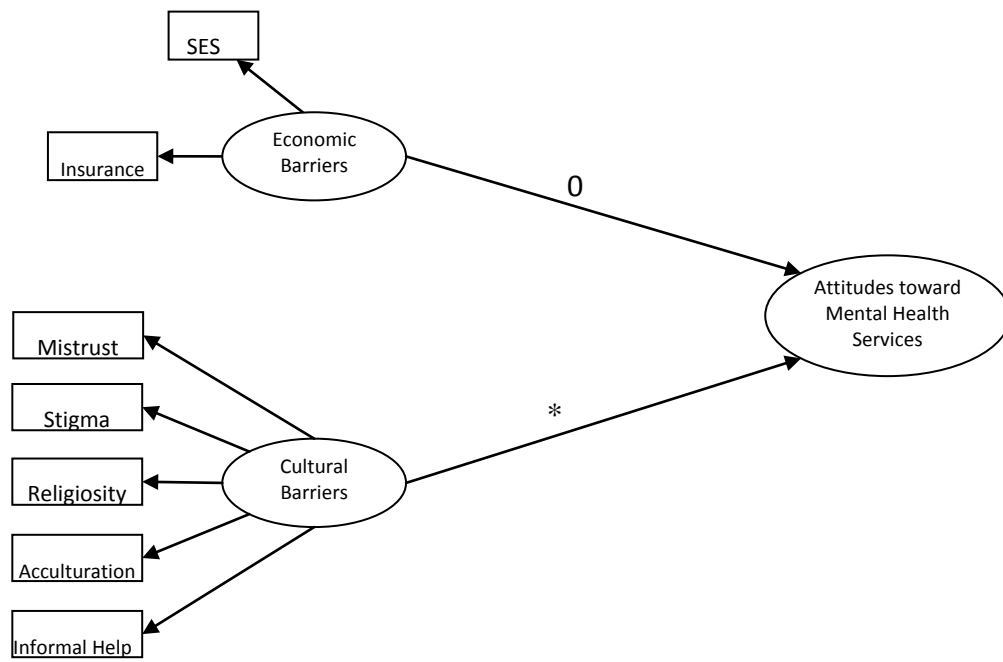


Figure 1.2

Model Depicting only Economic and Cultural Barriers' Impact on Help-seeking



## Chapter Two

### Methodology

The goal of this study was to investigate the relative role of economic factors compared to cultural factors in predicting African Americans' attitudes toward seeking professional mental health services. This chapter describes the methodology used to conduct this study.

#### *Participants*

Participants were 177 African American adults recruited from community organizations, social organizations, and churches in several metropolitan areas including Lexington, KY, Dallas, TX, and Cleveland, OH. Additionally, 98 participants from various metropolitan areas throughout the U.S. were solicited by email to complete the protocol online, for a total of 275 participants who completed the study during Spring 2008. However, 10 participants were later dropped from analyses due to excessive missing data on target measures. Analyses were performed on a sample of 265.

The largely female (63%) sample averaged an age of 41.7 (SD = 15.71) and ranged in age from 18 to 79. In terms of level of education, participants, at the time of data collection, had attained an average level of 16.8 (SD = 2.71) translating to partial college education according to the Barratt Simplified Measure of Social Status. In terms of occupation, participants averaged an occupation score of 32.02 (SD = 7.87), which translates to most of the sample having an income comparable to that of a librarian or electrician. Given that the adult aged sample was primarily in their 40's, it was not surprising to find that the majority of participants (about 57%) indicated they were currently married, and only about 21% were currently full time students.

#### *Measures*

*Cultural barriers.* Five cultural barriers mentioned in chapter one were assessed, namely cultural mistrust, stigma, religiosity, self-reliance, and acculturation.

Cultural mistrust. The most common and frequently utilized instrument to assess this construct is the Cultural Mistrust Inventory (CMI; Terrell & Terrell, 1981), a 48-item inventory developed to assess the extent to which African Americans mistrust Whites (see Appendix C). It assesses four distinct areas of mistrust: education and training (e.g., "Blacks should teach their children not to trust White teachers"), interpersonal relations

(e.g., “Blacks should be suspicious of a White person who tries to be friendly”), business and work (e.g., “A Black person can usually trust his or her White co-worker”), and politics and law (e.g., “Blacks have often been deceived by White politicians”). Respondents rated their opinions using a seven-point Likert scale ranging from strongly disagree (1) to strongly agree (7). To obtain the subscale scores, points for each item are added; negatively keyed items are scored in the reverse direction. Higher scores indicate a tendency to be more distrustful of Whites. The current study used the total score derived by adding scores for all 48 items. The total score has proven reliable with both college students ( $\alpha = .89$ ; Nickerson et al., 1994) and psychiatric inpatients ( $\alpha = .85$ ; Whaley, 2002). Within the current sample, the total scale attained adequate internal consistency ( $\alpha = .94$ ). Average participant scores ( $m = 173.57$ ,  $SD = 34.89$ ) generally suggest moderate endorsement of cultural mistrust relative the potential range of scores (48 to 336).

Stigma. Stigma was measured with the 12-item Perceived Devaluation-Discrimination scale (Link et al., 1987; see Appendix D). Participants rated the degree to which they believe statements about how most people view current or former psychiatric patients (e.g. “Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time.”) using a 6-point Likert scale ranging from strongly agree (1) to strongly disagree (6). This instrument is unidimensional with higher scores representing greater perceived stigma. Estimates of internal consistency range from .76 to .88 among clinical and community samples (Link et al., 1989, 2001). Within the current sample, the scale attained adequate internal consistency ( $\alpha = .82$ ). Average participant scores ( $m = 47.62$ ,  $SD = 8.70$ ) generally suggest moderately high endorsement of perceived stigma relative the potential range of scores (6 to 72).

Religiosity. Religiosity was assessed using the Religious Commitment Inventory – 10 (RCI-10; Worthington et al., 2003), a new, brief measure of religiosity designed to assess “the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living” (p. 85). Participants answered 10 items scaled on a five-point Likert scale ranging from not at all true of me (1) to totally true of me (5). Potential scores ranged from 10 to 50, with higher scores indicating greater religious



commitment. Example items include “Religious beliefs influence all my dealings in life” and “I enjoy working in the activities of my religious organization” (see Appendix E). Worthington and colleagues (2003) reported a full scale alpha of .95 for a religiously diverse sample of 468 undergraduate students and .88 for a sample of 150 Christian college students. Within the current sample, the total scale attained adequate internal consistency ( $\alpha = .94$ ). Average participant scores ( $m = 36.07$ ,  $SD = 10.24$ ) generally suggest moderately high endorsement of cultural mistrust relative the potential range of scores.

Self reliance/Informal help. Use of informal help was assessed with a single item question patterned after the National Survey of American Life battery, a well known longitudinal study of African American attitudes and behaviors. Participants were asked to rank order their likelihood of utilizing formal and informal resources for help with problems with emotions or other mental health concerns (see Appendix G). Options included psychiatrist; general practitioner or family doctor; any other medical doctor; psychologist; social worker; counselor; any other mental health professional such as a psychotherapist or mental health nurse; a nurse, occupational therapist, or other health professional; a religious or spiritual advisor like a minister, priest, or rabbi; any other healer, like an herbalist, chiropractor, or spiritualist; a spouse, partner, or family member; or self reliance, attend to concern yourself, or wait for improvement. Participants were to rank these in order from one to 12 with one indicating the source they would seek out first and 12 indicating the source they would seek last. Scores were determined by assessing how participants rank informal help sources (i.e., self; family member or spouse; healer, or religious/spiritual advisor). Rank orders for these three sources of help were summed. The sum of rankings for self, family, and “other” sources of help provides a rough estimate of participants’ preferences for these informal help sources. For example, a participant who ranked these sources at the top of their preference list (i.e., 1, 2, 3 with a sum score of 6) has a greater preference for informal help sources than someone who ranked these sources at the bottom of their preference list (i.e., 10, 11, 12 with a sum score of 33). Within the current sample, participants’ summed informal help scores had a mean of 22.65 ( $SD = 7.91$ ). Thus, low scores indicate higher preference for informal help while high scores indicate lower preference for informal help. Relative to

potential scores (ranging from 6 to 33), participant rankings indicate moderately low preference for informal help resources.

Acculturation. Acculturation was assessed utilizing the Measurement of Acculturation Strategies for People of African Descent (MASPAD), a measure based on the universal processes of acculturation, though formulated specifically for people of African ancestry (Obasi, 2004; see Appendix F). The MASPAD consists of 45 items assessing two dimensions of African American culture: traditionalist and assimilationist. (Obasi, 2004, p. 2). One item was dropped from analyses due to a typo on the protocol. Because I cannot be sure that all participants interpreted the item in the same manner, this item was not used in subsequent scale score tabulation or analyses. With the deletion of this item, only 44 MASPAD items remained; 22 items assessed the assimilationist dimension, and 22 items assessed the traditionalist dimension. Individuals rated their endorsement of African American acculturation strategies on a six-point continuum ranging from “strongly disagree” (1) to “strongly agree” (6). High scores on traditionalist subscale items (e.g., “I was socialized to treat my elders with respect”) reflect a preference for maintaining the heritage of one’s own ethnocultural group in behaviors and beliefs ( $\alpha = .84$ ), and high scores on assimilationist subscale items (e.g., “I do not feel connected to my African heritage”) reflect a preference for having contact with and participating in the society of a different ethnocultural group in behaviors and beliefs ( $\alpha = .65$ ). Reliabilities attained in the current study were comparable to those attained in the validation study for the traditionalist dimension ( $\alpha = .80$ ) but somewhat lower for the assimilationist dimension ( $\alpha = .75$ ). In the current study, participants attained average assimilationist scores of 67.01 (SD = 10.74), indicating a moderate endorsement of assimilationist behaviors and beliefs relative to the potential range of scores (22 to 132). For the traditionalist subscale, participants attained an average score of 92.18 (SD = 12.49), indicating a moderately high endorsement of traditionalist behaviors and beliefs relative to the potential range of scores (22 to 132).

*Social status.* The Barratt Simplified Measure of Social Status (BSMSS; Barratt, 2006) was used as a broad measure of socioeconomic status (see Appendix H). This measure was built on the work of Hollingshead (1957, 1975) who devised a simple measure of social status based on marital status, retired/employed status (retired

individuals used their last occupation), educational attainment, and occupational prestige. The list of occupations has been updated based on the work of Davis, Smith, Hodge, Hakao, and Treas (1991).

The BSMSS accounts for an individual's parent's educational attainment and occupational prestige and combines that with the individual's own family's educational attainment and occupational prestige. An arbitrary weighting was given of 2:1 for individual's family scores to parent's family scores. The choice of a 2:1 weighting recognized that the individual's current identity is the most important. Hollingshead's original conceptualization of educational attainment has been maintained faithfully, as has his weighting of educational attainment to occupational prestige of 3:5. The educational attainment score has the potential to range between 3 and 21 according to level of school completed. The occupational prestige score ranges between 5 and 45 according to prestige rating of the occupation. The total score simply adds the education and occupation scores, with scores ranging between 8 and 66. The current sample represented the entire range of both occupation and education scores and attained an overall average social status score of 48.89 (SD = 9.77), indicating the sample had moderately high social status scores relative to the potential range of scores.

Additionally, participants were asked whether they had health insurance or not. Responses were a dichotomous yes or no answer.

*Help-seeking attitudes.* Help-seeking attitudes were assessed with the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; see Appendix I), which was standardized on a sample of 208 adult volunteers (Mackenzie et al., 2004). While the full scale consists of 24 items, I inadvertently neglected to include 13 items from the measure when assembling the questionnaire packet (see Appendix I for items included and items not administered). This error in the production of the study protocol forced the use of an 11 item truncated scale within the current study (e.g., “I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.”). Participants provided responses using a five-point continuum ranging from “disagree” (1) to “agree” (5). High scores indicated a positive attitude toward seeking professional services for psychological problems.

The truncated version of the IASMHS attained reasonable reliability, improved by the deletion of one item ( $\alpha = .62$ ). After removing the problematic item (i.e. “Having been mentally ill carries with it a burden of shame”), the resulting 10-item scale was used in subsequent analyses. Surprisingly, participants in the current study endorsed relatively positive attitudes toward seeking mental health services, attaining a sample mean of 38.65 (SD = 5.81). However, in order to compensate for the missing items and resulting lowered reliability, correlations were corrected for attenuation caused by measurement error. Because measured variables contain random measurement error, certainly in this case, a correlation coefficient with another variable would be lower than the correlation coefficient between the true scores of those variables. As shown by Crocker and Algina (1986), failure to take into account such attenuation caused by measurement unreliability could potentially lead to erroneous conclusions about the relationships between the composites and about measurement validity coefficients. Thus, analyses that include the truncated IASMHS scale were corrected for attenuation using the formula:  $r_{TxTy} = r_{xy} / \sqrt{r_{xx}r_{yy}}$ , where  $r_{TxTy}$  refers to the corrected coefficient,  $r_{xy}$  refers to the attained correlation coefficient between x and y,  $r_{xx}$  refers to the reliability of measure x, and  $r_{yy}$  refers to the reliability coefficient of measure y.

*Demographics.* In addition to the aforementioned social status indicators, participants were asked to indicate various demographic variables including age, gender, marital status, full time student status, and current zip code.

#### *Procedure*

Data was collected via both traditional paper-pencil and internet methods.

*Traditional data collection.* After obtaining approval from the institutional review board, I contacted individuals associated with community organizations, social organizations, and churches in Lexington, KY; Dallas, TX; and Cleveland, OH with whom I had personal relationships. Data from Dallas, TX came from Hamilton Park United Methodist Church, Plano Community Forum (a community service group), and First Horizon (a financial institution). Data from Cleveland, OH came from employees of Vocational Guidance Services (a comprehensive service agency). Data from Lexington, KY came from Shiloh Baptist Church; Links, Incorporated; and the University of Kentucky (UK) Psychology 100 subject pool (see Table 2.1 for sample statistics by

collection site). Individuals within each of the Dallas and Cleveland collection sites, in addition to the Lexington, KY Links, Incorporated organization, (i.e., church pastors, organization officers, employees, etc.) were contacted to discuss availability and willingness of the members of their respective organization to participate in this study. These individuals were provided with a brief synopsis of the current study and given information regarding what would be required for participation, amount of time needed to complete the study, and potential benefits of the study. These individuals, then, disseminated this information within their respective organizations as a means of soliciting participants. Subsequently, these individuals reported back to me whether or not people within their organization would be interested in participating. After receiving reports that there was interest in participating in this study, I traveled to each of these data collection sites to collect data. Data collection times were set up so that I could distribute the protocol to participants in a group format. After I briefly described the current study to potential groups of participants, participants were given informed consent forms. Once informed consent was obtained, participants completed protocol packets and returned them. After completing the instruments, participants were able to submit their names and email addresses to be entered into a drawing to win one of three \$100 gift cards to Target or Wal-Mart. All identifying information was kept separate from study protocols.

Data from Lexington, KY collection sites was collected in an identical manner, though the method of recruitment was different for the UK Psychology 100 and Shiloh Baptist Church data. UK students were solicited to participate utilizing the Experimentrix recruitment site. All UK Psychology 100 students are required to complete a specified number of research credits and can sign up for these studies on the Experimentrix site. I placed a solicitation for African American students on the Experimentrix site during Spring 2008. Students who signed up for the study came to research rooms in small groups to complete the protocol as described above. Just as with other participants, UK students, in addition to receiving course credit, were able to enter their names into the prize drawing.

Recruitment at Shiloh Baptist Church took place in a more informal manner. I approached members of the church after a Sunday morning worship service and asked for their participation in the study after providing them with a brief synopsis. Participants

were able to complete the protocol on an individual basis on site or at home and return it to me the following week. Upon return of the completed packet, participants from Shiloh Baptist Church were able to enter their names into the prize drawing.

*Internet data collection.* Participants who completed the protocol online were recruited via email. I sent an email (see Appendix J) to friends and family and requested they forward the email to other African American adults who could potentially participate in the study. Participants originated from various metropolitan locations across the U.S. Recruitment through email ensured that participants had access to the internet, were familiar with the internet, and were capable of completing an online survey. I used MRInterview to collect and store online data. MRInterview is a secure online survey software package that is available to faculty, students, and staff at the University of Kentucky. It allows researchers to design and deploy surveys completely online from any computer with an internet connection. It uses SSL (Secure Sockets Layer) protocol to securely collect and deliver the data.

Directions within the email (see Appendix J) directed participants to a website generated with MRInterview. This website contained a letter describing the IRB approved study and how they would be contributing to the body of knowledge regarding African American help seeking. A copy of the introductory letter is provided in Appendix A. Informed consent was implied by clicking continue and logging in to the survey after reading the introductory letter. Accordingly, there was no written documentation of informed consent for the online participants, as is common in internet studies approved by the IRB. The introductory letter was followed by several self-report measures that took approximately 30 minutes to complete. Participants completed measures anonymously; that is, no identifying information (e.g., name, social security number, etc.) was asked on their questionnaires. After completing the instruments, participants were directed to a separate website, not connected to their survey responses, where they were able submit their names and email addresses to be entered into a drawing to win one of three \$100 gift cards to Target or Wal-Mart.

Table 2.1

Frequency of Participants within Each Data Collection Site

Collection Site	Frequency	Mean Age	Mean Education (3-21)
Hamilton Park UMC (Dallas)	80	51.80	16.78
Plano Community Forum (Dallas)	12	58.08	15.29
First Horizon (Dallas)	5	41.20	16.70
Vocational Services (Cleveland)	20	38.89	15.08
Shiloh Baptist Church (Lexington)	6	28.00	18.08
Links, Incorporated (Lexington)	17	58.06	17.44
UK PSY 100 Students (Lexington)	27	19.26	16.16
Online Survey	98	37.29	17.38

## Chapter Three

### Results

#### *Initial Attempt to Test Conceptual Model*

Prior to model testing, several steps must be taken in order to assure that data are prepared to enter a structural equation model. First, normality of the data must be assessed for the existence of skewness and kurtosis. If skewness or kurtosis levels are greater than the absolute value of 2, steps must be taken to transform the data to bring it back within acceptable range. Next, data must be analyzed for missing data, as a complete data set is necessary for SEM. Subsequently, the measurement models of the constructs must be analyzed in exploratory and confirmatory factor analysis, respectively. The measurement model refers to the fit of the observed indicators of the model (rectangles) and their relation to their target latent variable (ovals). Ideally, observed indicators should load unidimensionally. Only after confirmatory analysis indicates that fit is adequate can one test the structural equation model and assess model fit for relations among latent variables. This follows the stringent four-step modeling approach suggested by Mulaik and Millsap (2000). Results will be presented following this structure.

Analyses were run as planned with the goal of testing the initially proposed conceptual model (see Figure 1.2). However, model testing quickly became problematic, specifically at the measurement model stage of analysis. As shown in Figure 1.2, a number of distinct cultural constructs were grouped together under the culture latent variable. While religious commitment, acculturation, cultural mistrust, importance of informal help networks, and stigma are all important components of culture, these variables measure distinct constructs all their own and affect attitudes toward seeking mental health services in distinctly different ways. Rather than loading on a single factor, each of the five variables separately loaded on five distinct factors because they are five distinct constructs. This violates one of the assumptions of measurement models, that indicators should load unidimensionally on one factor. To facilitate the unidimensional loading of all cultural indicators onto a single latent factor, I simplified the measurement model. Rather than measure five constructs (i.e., religious commitment, acculturation, cultural mistrust, importance of informal networks, and stigma), I selected only one: acculturation.



Acculturation was chosen for a number of reasons. First, African American acculturation is an area of growing research, particularly as it pertains to the structure of acculturation within this population. Previously conceptualized as a unidimensional construct, more recent research has suggested that African Americans vary on two dimensions of acculturation, assimilationist behaviors/beliefs and traditionalist behaviors/beliefs. Additionally, there is a clear gap in the research as it pertains to cultural identity and attitudes toward mental health services. As mentioned in chapter two, limited research lends some evidence that acculturation may be a viable contributor to help-seeking attitudes. In one study investigating help-seeking behaviors for intimate partner violence (Lipsky, Caetano, Field, & Larkin, 2006), acculturation was predicted to have an effect on social services utilization. While researchers did find that low acculturation (greater adherence to practices and norms of one's ethnic group of origin) was associated with decreased utilization of social services, acculturation was only assessed in the Latina subsample but not the African American subsample. Given what we know about the importance and relevance of acculturation within the African American population, it would have been informative to assess for this cultural construct in Lipsky and colleagues (2006) study. Thus, in order to help fill the gap in the acculturation and help-seeking literature, the current study focused on a model testing these constructs of interest.

Additionally, while the initial model depicted economic barriers as a latent variable, the tested model only included social status as an economic indicator. The initial model conceptualized economic barriers as consisting of two observed indicators: social status and possession of insurance. However, SEM guidelines require that latent variables are predicted by at least three observed indicators. Thus, in order to stay in accordance with SEM guidelines and to further simplify the tested model, only social status was placed in the model as an observed variable. Social status was chosen due to its variability in responses.

With the above adaptations made, two models were compared: one in which the economic barrier of social status was freely estimated and one where that path was constrained.

*Normality and Descriptives*

Descriptive analyses were run to ascertain normality of acculturation, attitudes toward mental health services, and social status. Data yielded skewness and kurtosis values within the acceptable range (between +2 and -2) for items of target constructs. There was one exception with an item from the help-seeking attitudes measure (i.e., “If I were to experience psychological problems, I could get professional help if I wanted to.”). The majority of respondents answered in the affirmative, resulting in a negatively skewed item. To rectify the elevated skewness, a log transformation (i.e.,  $\text{LOG}(7-x)$ ) was utilized to bring the skewness and kurtosis levels back to within acceptable limits.

Other descriptive data indicated that the sample yielded positive attitudes toward mental health services ( $M = 38.65$ ,  $SD = 5.81$ ), moderately high social status ( $M = 48.88$ ,  $SD = 9.77$ ), moderately high endorsement of traditionalist behaviors and beliefs ( $M = 92.18$ ,  $SD = 12.49$ ), and average endorsement of assimilationist behaviors and beliefs ( $M = 67.01$ ,  $SD = 10.74$ ) relative to the potential range of scores on their respective scales.

#### *Missing Data*

Patterns of missing data were analyzed using SPSS’s Missing Value Analyses to uncover the amount and distribution of missing values. These analyses revealed that 10 participants had what was deemed excessive missing data. Excessive missing data was determined if missing data across at least two target variables was greater than 20% (e.g. more than 20% missing from the acculturation measure and the Inventory of Attitudes toward Mental Health Services). These 10 participants were not included in subsequent analyses because inclusion of incomplete data may skew data in unknown directions.

Subsequently, with the aforementioned participants removed from further analyses, data was assessed using Little’s missing completely at random (MCAR) test (Little, 1988). Results suggest that data show an MCAR pattern ( $\chi^2 = .000$ ,  $df = 828$ ,  $p = 1.00$ ), which is the optimal and desired resulting pattern for missing data. According to Little and Rubin (2002), when this test statistic is not statistically significant, as is the case in this study, it is safe to assume that the data show an MCAR pattern which means that missing values are randomly distributed across all observations. This is the broadest pattern of missingness and the best case scenario for missing data.

Since the data show an MCAR pattern, any missing data could be estimated using any of the standard techniques: substituting means on valid cases (pairwise or listwise),

substituting estimates based on regression, multiple imputation where each missing value is replaced by list of simulated values, or the maximum likelihood (EM) method where missing data is imputed with a best guess under current estimate of unknown parameters, then re-estimated from observed and filled-in data. The maximum likelihood method of estimation, as utilized in the current study, is particularly favorable in MCAR situations because it uses all the available data to generate the estimates of the missing data (Arbuckle, 2005). This method is the least biased of all of the options and preferred over others because it is an iterative method of estimating the missing data.

#### *Reliability Analyses*

Reliability analyses were run for the help-seeking measure and both subscales of the acculturation measure, assimilationist and traditionalist. Reliabilities were .61 for the assimilationist subscale and .84 for the traditionalist subscale. With the truncated attitudes scale, reliability was adequate but not optimal at .62 and only after one item was removed from analyses to improve reliability.

#### *Zero-Order and Corrected Correlations*

Bivariate correlations demonstrate that help-seeking attitudes was significantly correlated with assimilationist acculturation, traditionalist acculturation, and social status at or below the .01 level prior to any correction for measurement error. When correlations were corrected for attenuation with the formula mentioned above, correlations were even stronger in magnitude (see Table 3.1). Social status did not significantly correlate with either acculturation dimension. As anticipated, assimilationist acculturation and traditionalist acculturation inversely correlated with each other.

#### *Regression Analyses*

Regression analyses mirror results of the correlation analyses. Because there was no theoretical basis for determining the order in which predictors were entered, predictors were entered into the regression model utilizing the stepwise method. Stepwise regression is an automatic procedure used in cases where there are a number of potential explanatory variables. The stepwise regression algorithm determines the order in which predictors are entered into the regression model based on the significance and magnitude of their individual contributions. Social status emerged as the strongest predictor of attitudes toward seeking mental health services, followed by assimilationist acculturation and

traditionalist acculturation. These target constructs predicted a significant ( $p < .001$ ) 11.3% of the variance (see Table 3.2). No interaction effects were found among the predictors.

#### *Exploratory Factor Analyses*

Next exploratory factor analyses were run for the help-seeking attitudes, assimilationist acculturation, and traditionalist acculturation measures, as they represent latent variables to be estimated by SEM. In order to simplify the model, maximize on the variance to be predicted from the data, and maximize on power, parcels were created for each of the target variables. Parcels are typically linear combinations of multiple indicators within a construct (e.g., adding 2 or 3 items together). Parcels are not subscales and often have no inherent meaning, but are helpful in reducing bias. Given that the variable parcels will be used in subsequent analyses, variable parcels were used to ascertain the factor structure. For all constructs, parcels were created using random assignment, one of the recommended techniques for building parcels according to Little and colleagues (2002).

Five parcels were created for help-seeking attitudes by summing two random items from the instrument. By estimating with five parcels, I was able to capture a similar response pattern with a more manageable number of items for SEM. Following this same rationale, four parcels (of approximately five items each) for each of the traditionalist and assimilationist dimensions of African American acculturation were entered into the exploratory factor analysis. Using a principal components extraction with varimax rotation, three clear factors emerged as expected. The parcels used to measure attitudes toward seeking mental health services, assimilationist acculturation, and traditionalist acculturation loaded on their respective factors with item loadings ranging from .41 to .85, indicating that these items may be conceptualized as unidimensional within their respective scales (see Table 3.3).

#### *Confirmatory Factor Analyses*

Given the emergence of strong correlations among help-seeking attitudes, social status, traditionalist acculturation, and assimilationist acculturation, reasonable scale reliabilities, promising internal factor structures among constructs, and no apparent problems with data normality, the preliminary data warranted the verification of the

measurement models in AMOS using confirmatory factor analysis. Subsequently, the factor structure for each latent variable (help-seeking attitudes, assimilationist acculturation, and traditionalist acculturation) was tested using confirmatory factor analysis in AMOS.

For the following CFA and SEM analyses, several fit indices were reported: the comparative fit index (CFI), the Tucker-Lewis index (TLI), the root mean square error of approximation (RMSEA), the standardized root mean square residual (SRMR), and the Akaike Information Criterion (AIC; Akaike, 1987). The CFI and the TLI each represent the proportion of improvement a model provides over a null model in which none of the variables are related to each other. Some general standards or rules of thumb for establishing fit of the models are CFI and TLI values that are .90 represent good fit and .95 represent excellent fit (Hu & Bentler, 1999; Kline, 2005). The RMSEA, a slightly different type of fit index, adjusts for the complexity of a model, producing more favorable values for simpler, parsimonious models. RMSEA values of .06 are thought to indicate a close fit, .08 a fair fit, and .10 a marginal fit (Brown & Cudeck, 1993; Hu & Bentler, 1999). These rules of thumb are not unreasonable, but since RMSEA has no upper bound, an unstandardized RMSEA above such thresholds does not necessarily indicate a poorly fitting model. As RMSEA is difficult to interpret, SRMR is recommended instead. Closely related to RMSEA, the SRMR involves a direct comparison of the covariance matrix implied by the model and the actual covariance matrix obtained in the study. It represents the average deviation between the implied and obtained values for a given covariance. In general, SRMR follows the same rules of thumb as RMSEA where the smaller the value, the better the model fit.

AIC is a goodness-of-fit measure that adjusts model chi-square to penalize for model complexity (that is, for lack of parsimony and overparameterization). Thus AIC reflects the discrepancy between model-implied and observed covariance matrices. AIC is used to compare models and is not interpreted for a single model. It may be used to compare models with different numbers of latent variables, not just nested models with the same latent variables but fewer predicted paths. The absolute value of AIC has no intuitive value, except by comparison with another AIC, in which case the lower AIC reflects the better-fitting model (Burnham and Anderson, 1998). For comparison of the

two simplified models, AIC was assessed in addition to standard chi-square difference tests.

Factor loadings for the measurement model of attitudes toward seeking mental health services ranged from .28 to .76, indicating some variability in the strength of item parcels to predict the construct. There was a noticeable drop in factor loadings from the exploratory factor analyses to the confirmatory factor analyses for IASMHS parcel five (see Table 3.3 and Figure 3.1). While attaining a reasonable .41 loading in EFA, the confirmed loading of .28 does raise questions regarding the stability of that parcel. However, in confirming the structure of the measurement model for the attitudes toward seeking mental health services, fit indices were as follows: CFI = 1.00, TLI = 1.04, RMSEA = .00, and SRMR = .02. Based on these fit indices, these five item parcels provide an excellent fit for the measurement model of attitudes toward mental health services (see Figure 3.1) and accurately represent the pattern of responses within the current sample.

Factor loadings for the measurement model of assimilationist acculturation ranged from .50 to .62, indicating relative consistency in the strength of item parcels to predict the construct. In confirming the structure of the measurement model for the assimilationist acculturation, fit indices were as follows: CFI = .98, TLI = .94, RMSEA = .07, and SRMR = .03. Fit indices clearly indicate that these four item parcels provide an good fit for the measurement model of assimilationist behaviors and beliefs (see Figure 3.2).

Factor loadings for the measurement model of traditionalist acculturation ranged from .72 to .81, indicating relative consistency in the strength of item parcels to predict the construct. In confirming the structure of the measurement model for the traditionalist acculturation, fit indices were as follows: CFI = .97, TLI = .91, RMSEA = .15, and SRMR = .03. While the value for RMSEA clearly did not fall within the rule of thumb for desired fit, SRMR and the other two indices all indicate excellent fit. CFA generally reflects that these four item parcels provide a good fit for the measurement model of traditionalist behaviors and beliefs (see Figure 3.3) and emphasizes the need to assess multiple fit indices.

#### *Testing the Simplified Model*

Given that the measurement models of all latent variables showed good fit, the next step was testing and comparing structural models. Preliminary analyses have suggested strong relationships between attitudes toward seeking mental health services and both acculturation and social status. Thus, it was expected that SEM analyses would reflect this same pattern of results. The null structural model tested (see Figure 3.4), shows direct paths from assimilationist and traditionalist dimensions of acculturation to help-seeking attitudes. An additional estimated path included a covariance between acculturation dimensions, as theoretical literature and current findings suggest they should correlate. Also of specific interest was the freely estimated path from social status to help-seeking attitudes. Results were somewhat mixed regarding fit of the null structural model. CFI = .90, TLI = .87, RMSEA = .07, and SRMR = .07. While CFI, RMSEA, and SRMR all indicate adequate fit, TLI reflects a poor fit. Fit for the alternate model where the path from social status to help-seeking attitudes was constrained was generally weaker than the null model fit in that CFI = .87, TLI = .85, RMSEA = .07, and SRMR = .08. While RMSEA and SRMR indicate adequate fit, TLI and CFI reflect a poor fit.

A rudimentary inspection of the AIC index (see Figures 3.4 and 3.5) shows a lower value for the freely estimated model, suggesting the data better fit this model when compared to the constrained model. Additionally, a chi-square difference test was performed on the aforementioned nested models to assess which best fits the current data (see Table 4.4). This measures the significance of the difference between two SEM models of the same data, in which one model is a nested subset of the other. Specifically, chi-square difference is the standard test statistic for comparing a modified model with the original one. If chi-square difference shows no significant difference between the unconstrained original model and the nested, constrained modified model, then the modification is accepted. A statistically significant chi square difference test indicates that simplifying the model has significantly worsened the fit of the model to the observed data. Table 4.4 shows that the chi square difference is, indeed, significant indicating that the null model, where social status was estimated freely, is a better fit of the current data than the alternate model, where that path was constrained. For this reason, the null model was retained and interpreted.

The retained model simply depicts the relationship between acculturation, attitudes toward seeking mental health services, and between social status and attitudes toward seeking mental health services among a community sample of African American adults. As expected, both assimilationist acculturation and traditionalist acculturation significantly covaried within the structural model, attaining a standardized regression weight of  $-.35$ . Factor loadings for the observed variables were comparable to those obtained in the measurement model. The structural model includes three direct paths, one from each assimilationist and traditionalist orientations of acculturation and one from social status, to help-seeking attitudes. It was anticipated that both acculturation latent variables would have an impact on attitudes toward seeking psychological help. However, as shown in Figure 3.4, standardized regression weights from assimilationist acculturation to help-seeking attitudes and from traditionalist acculturation to help-seeking attitudes were  $-.30$  and  $.09$ , respectively. Only the path from assimilationist acculturation was significant at the  $.01$  level. Additionally, as reflected in preliminary analyses, the path from social status to help-seeking attitudes also emerged as significant. Its standardized regression of  $.29$  was significant at the  $p < .001$  level. When corrected for attenuation, the regression weights for direct paths from assimilationist acculturation, traditionalist acculturation, and social status increase in magnitude to  $-.47$ ,  $.12$ , and  $.49$  respectively.



Table 3.1

Intercorrelations among Help-Seeking Attitudes, Acculturation, and Social Status

Factor	1	2	3	4
1. Help-Seeking Attitudes	--			
2. Social Status	.25**(.42**)	--		
3. Assimilationist	-.21**(-.33**)	-0.07	--	
4. Traditionalist	.18**(.24**)	0.07	-0.23**	--

Corrected Correlations in parentheses ( )

\*\* . Correlation is significant at the 0.01 level (2-tailed).

Table 3.2

Results of Stepwise Multiple Regression on Help-Seeking Attitudes

Variable	B	SE B	$\beta$	Model R <sup>2</sup>	Significance of Increase to R <sup>2</sup>
Step 1					
Social Status	0.17	0.04	0.25	0.06	0.00
Step 2					
MASPAD Assimilationist	-0.11	0.03	-0.20	0.10	0.00
Step 3					
MASPAD Traditionalist	0.06	0.03	0.12	0.11	0.05

Table 3.3

Factor Loadings for Acculturation and Help-Seeking Attitudes Item Parcels in EFA

Measure subscale	Factor Loading		
	1	2	3
Traditionalist Parcel 1	0.85		
Traditionalist Parcel 2	0.81		
Traditionalist Parcel 3	0.79		
Traditionalist Parcel 4	0.78		
IASMHS Parcel 1		0.77	
IASMHS Parcel 2		0.67	
IASMHS Parcel 3		0.61	
IASMHS Parcel 4		0.59	
IASMHS Parcel 5		0.41	
Assimilationist Parcel 1			0.78
Assimilationist Parcel 2			0.75
Assimilationist Parcel 3			0.63
Assimilationist Parcel 4			0.55
Eigenvalue	3.32	1.95	1.67
Variance explained (%)	25.55	14.98	12.84

Table 3.4

Chi Squared Difference Test

	$\chi^2$	df	Sig
Model 1 (Free)	157.49	74	0.00
Model 2 (Constrained)	173.63	75	0.00
Difference	16.14	1	0.00

Figure 3.1

Measurement Model of Attitudes toward Seeking Mental Health Services (Using Parcels)

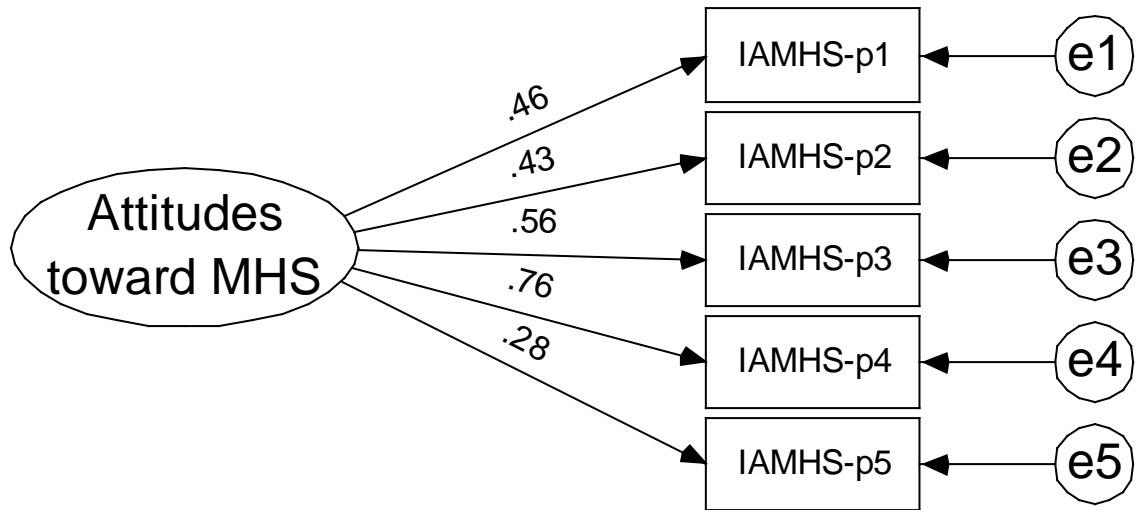


Figure 3.2

Measurement Model of Assimilationist Behaviors/Beliefs (Using Parcels)

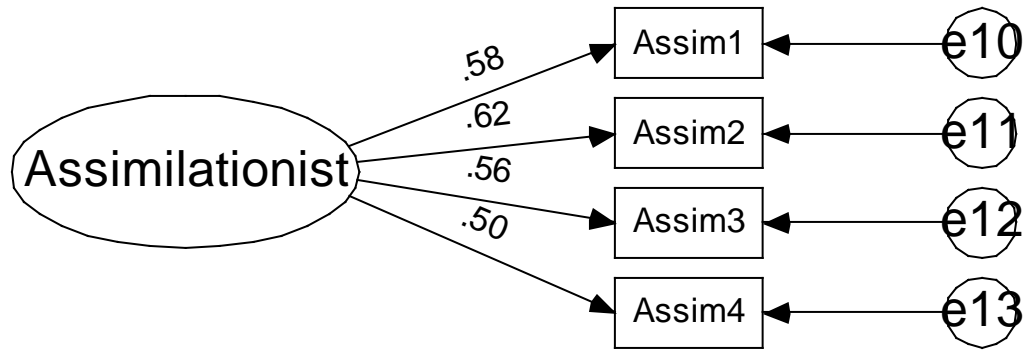


Figure 3.3

Measurement Model of Traditionalist Behaviors/Beliefs (Using Parcels)

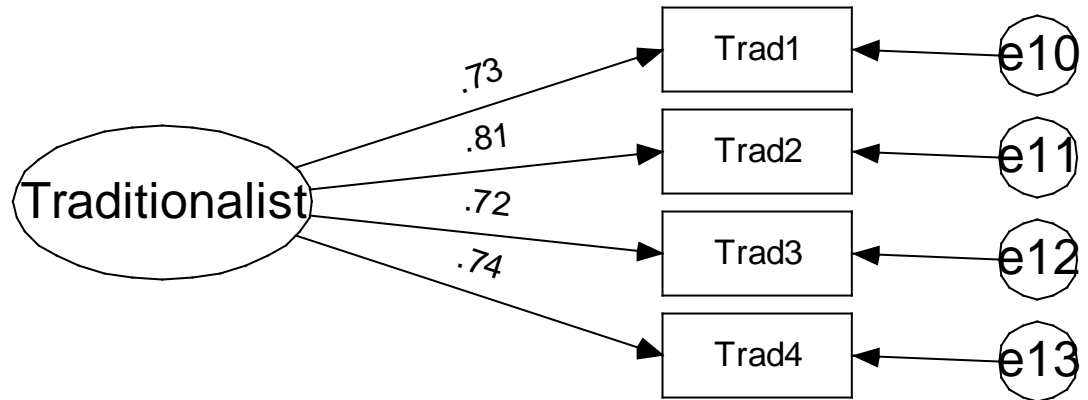


Figure 3.4

Structural Model with Social Status Estimated Freely

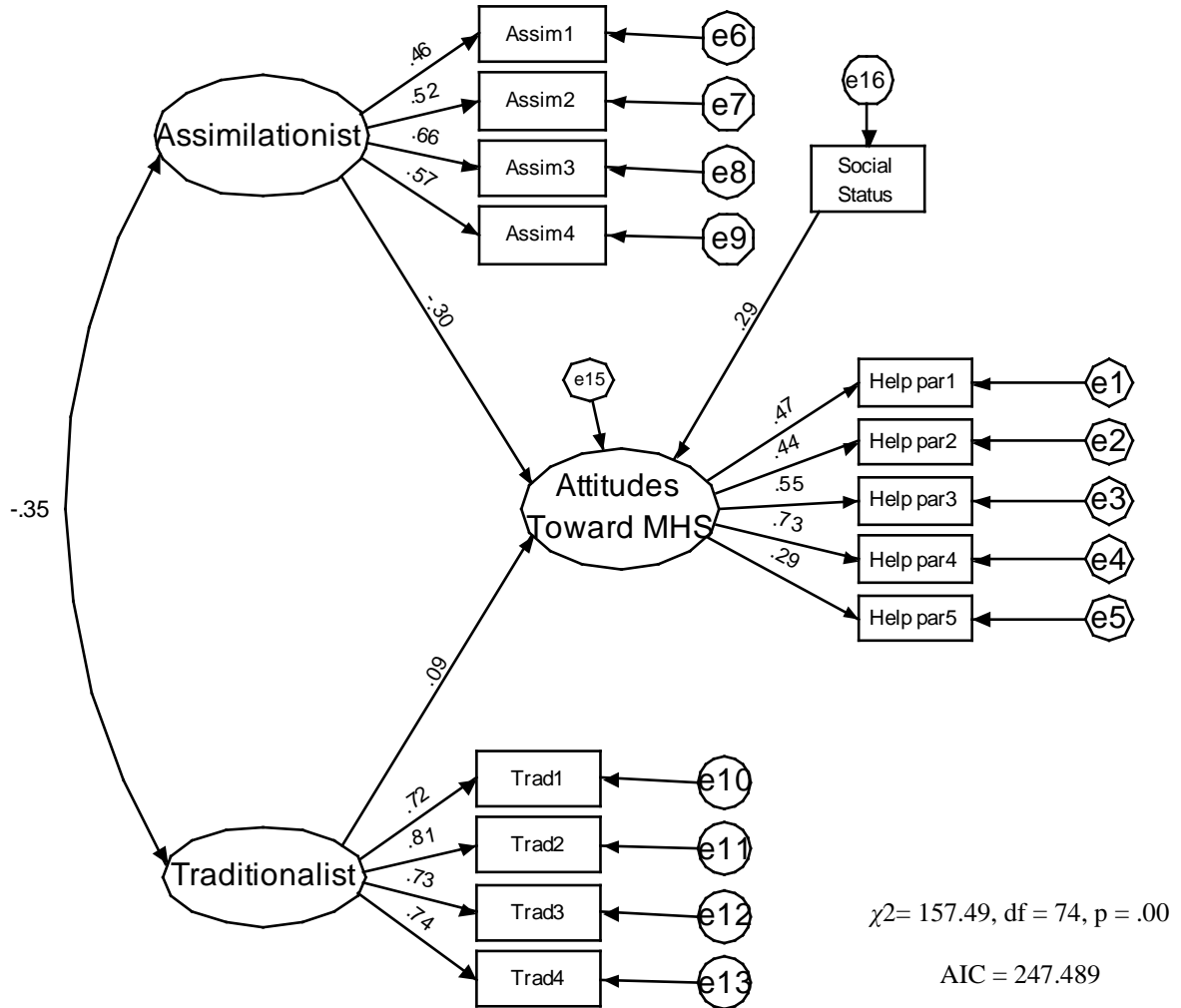
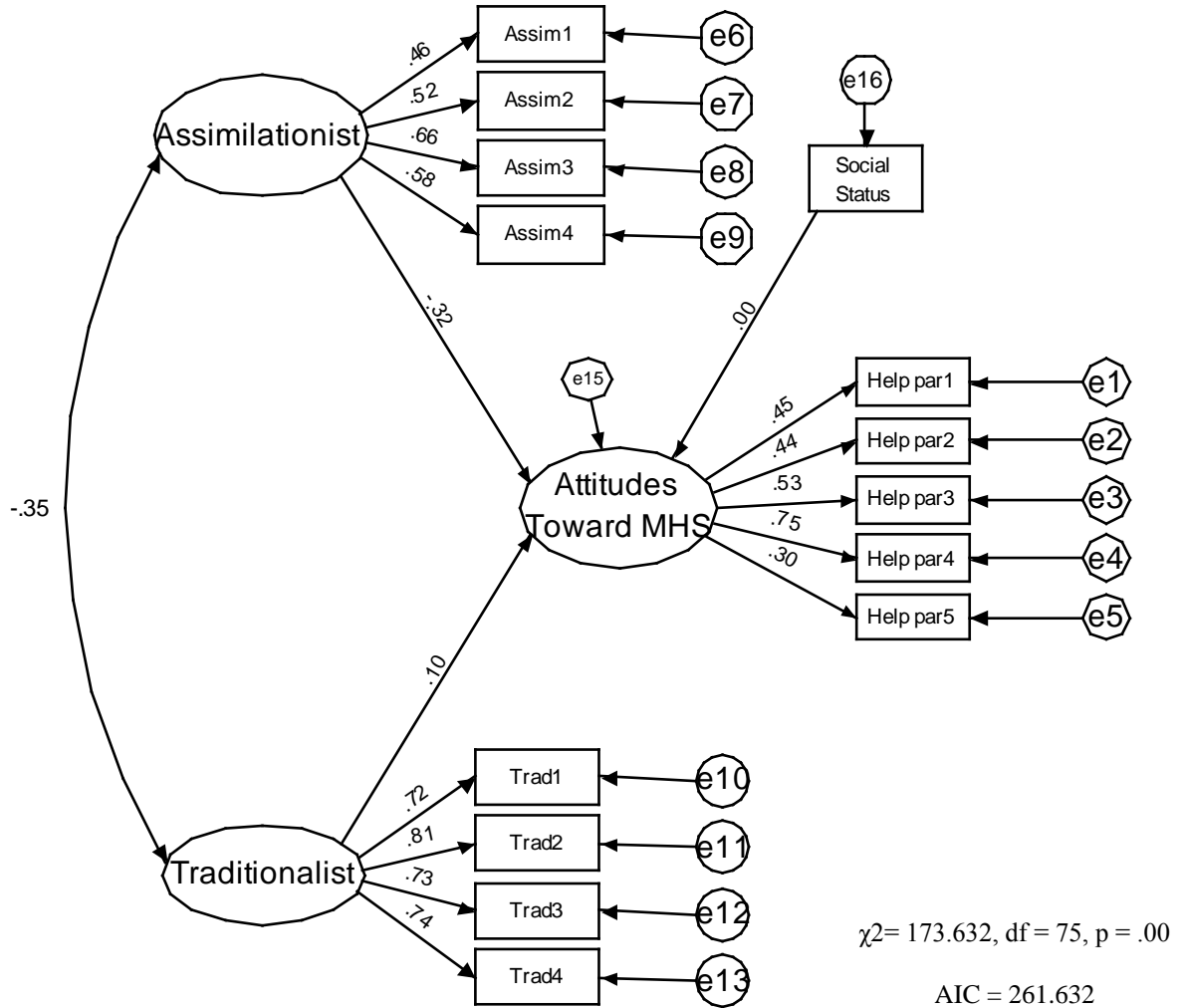




Figure 3.5  
Structural Model with Social Status Constrained



## Chapter Four

### Discussion

Research indicates that the percentage of African Americans receiving needed care is half that of non-Hispanic Caucasians (DHHS, 2001a). This occurs largely due to underutilization of services by African Americans. While a number of structural barriers like cost, fragmentation of services, and lack of services may lead African Americans to underutilize mental health services (DHHS, 1999), perhaps even more noteworthy deterrents include mistrust and fear of treatment, racism, and discrimination, among others. Without question, these factors have led to African Americans' unfavorable perceptions of mental health treatment (Carten, 2006). Many of these deterrents have stemmed from African Americans' historical experiences with formal institutions of care. Considering their gross mistreatment within these institutions, the utilization of racist assumptions as the base of mental health services, and a history of devaluing and demeaning African Americans in the U.S., it should come as no surprise that African Americans are reluctant to receive treatment. Indeed, the historical experiences of African Americans in the U.S. have provided the lens through which African Americans perceive mental health services. Even so, evidence demonstrates that mental health services do not take this contextual lens into account; often, the "uniqueness of the black cultural experience" (Carten, 2006, p. 129) is left out of the service utilization equation. Research indicates that culture is a viable and necessary factor to consider regarding African Americans' pattern of underutilization of services. Cultural beliefs are key deciding factors in whether people seek help in the first place (DHHS, 2001b) and likely influence every step in the help seeking process from recognizing symptoms to deciding on a service provider (Cauce et al., 2002). However, no one has put forth a culture-specific model of help seeking for African Americans that might help explain how specific cultural factors impact help seeking attitudes and behaviors. The current study sought to fill this significant gap in the literature.

Instead of culture, many have leaned upon the economic-based explanation for African Americans' underutilization of services. Specifically, many have claimed that differences in mental health service utilization rates are solely due socioeconomic status, income, and the like (Hollar et al., 2007). While Neighbors (1991) reports that low-

income African Americans are 1.5 times more likely to utilize counseling services than high-income African Americans, still other researchers (i.e., Baker, 1977; Tischler, Heinsz, Myers, & Boswell, 1975) report that education and income do not differentiate at all between African Americans who frequent mental health facilities and those who do not. These contradictions highlight the difficulty in separating utilization based on SES (Kessler & Neighbors, 1986; Williams & Collins, 1995) and suggest the decision to use professional mental health services is more complex than can be explained by economic barriers alone. An additional goal of the current study was to clarify the role of socioeconomic status in African American help seeking and determine if culture was better able to account for the complexities in African Americans' attitudes toward seeking mental health services.

To achieve both of the aforementioned goals, the current study tested a model of attitudes toward seeking mental health services among a sample of African American adults. The current study sought to clarify whether economic factors predict attitudes toward mental health service use after the effects of cultural factors are taken into account. While initially I conceptualized a full model to help explain African American attitudes toward seeking mental health services, statistical constraints prevented it from being tested. A more simplified model focused on African American acculturation and social status to help answer questions regarding the relative importance of culture and economic factors. Results indicated that social status is, in fact, significantly related to African American attitudes toward seeking mental health services. Specifically, the general pattern of results suggests that African Americans with high social status ratings have more positive attitudes toward seeking help. Results also indicate that the assimilationist behaviors and beliefs was also a strong predictor of these attitudes. Individuals with more assimilationist behaviors and beliefs seem to have more negative attitudes toward seeking help. Bivariate correlation findings also indicate that traditionalist behaviors and beliefs was a significant, but not as strong, predictor of help-seeking attitudes. Participants who indicated more traditional behaviors and beliefs had more positive attitudes toward seeking mental health services. However, when all of these factors were placed in a structural equation model, results indicate a similar pattern of relationships with one notable distinction. Specifically, traditional behaviors and

beliefs did not emerge as a significant predictor within the full model. The model provided a significantly better fit when social status was estimated freely, meaning the regression weight was not specified as a specific value but freely estimated in the model. Overall, findings seem to support the importance of cultural factors like acculturation, but also provides some empirical evidence for including economic factors like social status in explaining African American attitudes toward seeking mental health services.

While the current study was successful in achieving its main goals of establishing statistical evidence for the widely theorized role of economic factors and found support for the importance of African American culture, other interesting challenges and findings emerged. I will discuss the role economics and culture play in attitudes toward seeking help, conclusions drawn from findings, and suggestions for gearing future research toward resolving some of the limitations presented in the current study.

#### *Role of Socioeconomic Status in Determining Help Seeking Attitudes*

The current study sought to clarify the relationship between social status and African Americans' attitudes toward seeking mental health services. While many claim a link between help-seeking attitudes and socioeconomic status (Duncan, 2003; Neighbors, 1991), SES unfortunately has no universal definition. Within the international research literature, socioeconomic status has been related to social class, social position, occupational status, educational attainment, income, wealth and standard of living (Amaddeo & Jones, 2007). Within the current study, the Barratt (2006) social status ranking was utilized as a proxy of SES, a composite of education and occupation ratings. One of the significant findings that emerged from the current study was that social status was, in fact, a significant and robust predictor of African Americans' attitudes toward seeking mental health services. Additionally, social status not only emerged as the strongest predictor in regression analyses, but was also a key variable in maximizing model fit in the tested model. When comparing the opposing models, model fit suffered significantly when social status was constrained. The predominant contention of the current study was that culture, not economic indicators, would provide the strongest predictive power in determining help seeking attitudes. That theory was not supported in the current study.

While social status findings from the current study are robust, they are somewhat difficult to frame within the scope of the existing literature. First off, research investigating the link between economic indicators and help seeking among African Americans has yielded inconsistent results. Older research studies from the 1970's all seemed to lean in the direction of SES being a moot point when it comes to distinguishing African American attitudes toward seeking mental health services (i.e., Baker, 1977; Tischler, Heinsz, Myers, & Boswell, 1975; Wolkon et al., 1973). Some contemporary research, however, indicates that African American help seeking attitudes and behavior can be differentiated according to SES. Duncan (2003) and Neighbors (1991) have provided two of the few studies that have exclusively studied African Americans and their help seeking preferences based on socioeconomic status. Both studies reported African Americans with lower incomes tended to have more positive help seeking attitudes and behaviors. Those findings are contradictory to that which was found in the current study. However, current findings fit an emerging pattern of results from recent research. Neighbors and colleagues (2007) found that SES, specifically education level, showed a positive relationship with mental health service use within an adult African American sample. They explain that education level is likely a proxy for knowledge, greater attentiveness to mental health information, and awareness of the availability and acceptability of seeking help for mental health problems. The same might be said for the current sample. In general, sample characteristics suggest that participants were highly educated and generally savvy. This may have contributed to their propensity for and openness to seeking mental health services.

A remaining question is: Why were socioeconomic indicators unsuccessful in differentiating help seeking attitudes 30 years ago, but demonstrate importance now? Generally speaking, it seemed that African Americans' attitudes toward seeking mental health services were universally wrought with stigma regardless of SES. It is likely that the findings of Baker (1977), Tischler and colleagues (1975), and Wolkon and colleagues (1973) were an accurate reflection of attitudes during that time. Psychology, therapy, counseling, and the like were topics rarely discussed out in the open and treated in an almost secretive and shameful manner. Though, with more African Americans in the U.S. middle class now than ever before (DHHS, 2001b), the population is more educated,

informed, and has greater access to psychological information and services. For some, it seems, these factors lead to increased positive attitudes toward seeking those services.

Though social status was deemed important within the current study, extant literature urges researchers to look beyond it as a sole explanation for differences in help seeking attitudes and behaviors. Results suggest that participants with higher social status ratings had more positive attitudes toward mental health services. This finding is supported by the literature among other ethnic groups including Caucasian Americans (Richman et al., 2007). Typically, individuals with high social status have more income, better resources, better education, greater accessibility to services, and have more services available to them, regardless of ethnic group (DHHS, 2001b). It makes sense that these individuals would feel more comfortable with seeking mental health services; it is likely not as foreign, scary, or intimidating to them as it might be for someone with lower income who does not have the benefit of access and availability to services. Though, this has not always been the case for African Americans, as other factors like culture and historical experience seem to convolute this relationship. These findings highlight the importance of looking beyond structural variables to explain disparities in mental health care utilization and call for additional focus on individual and cultural variables.

#### *The Role of Culture on African Americans' Attitudes toward Mental Health Services*

The second, and arguably more critical, aim of the current study was to investigate the role cultural factors play in African Americans' attitudes toward seeking mental health services. One of the more challenging findings to explain was the relationship between attitudes toward seeking mental health services and acculturation. Specifically, regression findings indicated that assimilationist acculturation and traditionalist acculturation both predicted African American help seeking attitudes and accounted for a significant (11.3%;  $p < .001$ ) proportion of the variance in attitudes toward seeking mental health services. However, when placed in a structural equation model, only the assimilation orientation emerged as a significant cultural predictor of these attitudes. Though the traditionalist subscale of the MASPAD was not strong enough to yield significant findings in the structural equation model testing, the data suggested that greater assimilation was consistently associated with more negative attitudes toward

seeking mental health services. Essentially, participants who reported less assimilation to mainstream culture endorsed more positive help seeking attitudes.

This finding supports the growing body of literature that suggests that African Americans who do not endorse assimilation behaviors and beliefs may be more psychologically healthy. Historically, African Americans have had poor attitudes toward seeking mental health services and have not sought them out regardless of need. Research indicates that despite the fact that 63.6% of over 2,000 African Americans in a national survey reported experiencing serious personal problems (Leong, Wagner, & Tata, 1995), the percentage of African Americans receiving needed care is only half that of non-Hispanic Caucasians (DHHS, 2001a). African Americans do have mental health problems, and attitudes toward seeking mental health services informs us about actual help seeking behavior. If African Americans have negative attitudes toward seeking mental health services, they are unlikely to seek them out. However, if African Americans have more positive attitudes toward seeking those services, as was the case in the current study, they may be more willing to get help for reported problems. The current study suggests that not only do more African Americans seem to be willing to seek help, but that this willingness is associated with low endorsement of assimilation to mainstream culture. Less assimilated African Americans who endorsed more positive attitudes toward seeking mental health services may possess a heightened ability to cope with mental health problems and willingness to do so by whatever means necessary. After all, in the extant literature, level of acculturation has been shown to be associated with many aspects of behavior among people of color in the United States. High levels of acculturation toward mainstream U.S. culture have been shown to be associated with greater use of mental health services among female Chinese immigrants (Tabora & Flaskerud, 1997) and with a lower prevalence of smoking among African American men and women (Mokuau & Fong, 1994).

To clarify the overall pattern of results from the current study, but specifically to help explain why the traditionalist subscale did not pan out in model testing, post hoc t-tests were run to compare mean help seeking attitudes among acculturation strategies (traditionalist, assimilationist, marginal, and bicultural). T-tests indicated that significant differences only existed between Assimilationist /Traditionalists and also between

Marginal/Traditionalists. Overall, traditionalists seemed to have the most positive help seeking attitudes overall among all four strategies. Traditionalists were significantly more willing to seek mental health services than those who endorsed assimilationist and marginalist acculturation strategies. Coupled with the findings regarding low endorsement of assimilationist behaviors and beliefs, this provides compelling evidence regarding the virtue of maintaining cultural values and beliefs and rejecting those of mainstream American culture. While demonstrating significance in t-test and regression analyses, the traditionalist subscale may not have emerged as significant in the tested model due to lack of predictive power. Fewer tested variables and/or additional participants may have allowed this measured subscale to emerge as a significant predictor.

Recent research has suggested that it may be more psychologically healthy for African Americans to retain the values and beliefs of their own culture. Abdullah and Brown (2009) have shown that there are positive mental health indicators associated with traditional African American culture. They found that those with a traditional acculturation style had higher self-esteem than those with an assimilation acculturation style. This implies that those who remain true to African ideals and thoughts while adhering less to the ideals and thoughts of White US culture have more positive feelings about their worth as individuals than those who embrace White US thoughts and ideals while rejecting African ones. This finding is consistent with Berry et al's (2006) immigration study, which also found that traditional orientation was associated with positive psychological adaptation. Moreover, Phinney, Cantu, and Kurtz (1997) found that for African American adolescents, being oriented towards their own ethnic group rather than toward mainstream European identity indicators was associated with higher self-esteem, a pattern also reported by Martinez and Dukes (1997). Additionally, a study by Orozco and Lukas (2000) examined gender differences in acculturation and aggression as predictors of substance. Acculturation emerged as a better predictor of drug use than gender. Their results showed that women in the sample were much more traditional in acculturation and used fewer drugs. This implies that women who remain true to African traditions and culture tend to not use unhealthy coping practices like drug use.



While more recently published literature suggests that low endorsement of mainstream US cultural values and beliefs has positive mental health benefits, findings from the current study also suggest that those same beliefs may have an impact on African Americans' coping skills. Many classic "help seeking" studies completed during the 1970s, 80's and 90's (see Neighbors, 1985; Leong, Wagner, & Tata, 1995; Wolkon et al., 1973), rested on the literature that stated that African Americans do not utilize services due to lack of trust. However, current results suggest a dramatic shift in the relationship between African American culture and openness to seeking services from mental health professionals. While I suspect that this shift takes into account that many from the participant pool were upwardly mobile, educated, and open to new experiences, I also attribute the unexpected pattern of findings to the adaptive nature of African American people. Historically, a hallmark of African American culture has been their strong sense of resilience. African Americans have prided themselves on their ability to find methods of helping them "temper the storm," or cope with problems in order to carry on. Given the historical context presented in chapter one, this resiliency or "do what you have to do" attitude seems to have served this community well. African Americans have evolved over time to cope with challenges presented. Resiliency and resourcefulness have often been posited as characteristics that African Americans possess which have helped them deal with distress. These characteristics have allowed them to achieve and maintain a semblance of positive mental health despite living in an overtly oppressive society. African Americans have developed adaptive beliefs, traditions, and practices that have enabled them to survive.

Although traditional ethnic people of color have tended to rely on family and kin for social support during times of distress (Landrine & Klonoff, 1996), mental illness rates within this community continue to rise. Something about the old way of doing things has clearly not been successful in addressing these problems. Perhaps African Americans have begun to recognize this, that trained professionals are in fact more appropriate sources of help. In keeping with African Americans' resilient spirit, the current study suggests that African Americans are becoming increasingly open to using new methods of coping with problems when the old methods are not working. African Americans within the current sample, particularly those with low endorsement of

mainstream culture, appear more open to accessing services as a means of rebounding from challenges and coping in the face of adversity. Essentially, African American values of interdependence, cooperation, and mutual respect (Smyth and Yarandi, 1996) appear to support strategies that lead to positive coping skills including openness to seeking help for problems. Findings from the current study suggest African Americans may be adapting to incorporate more accepting attitudes toward mental health services into their values and beliefs.

The question remains as to why assimilationists have more negative attitudes toward seeking mental health services than traditionalists? It seems like there may be something inherently less healthy about taking on the values, beliefs and behaviors of another culture. Generally speaking, t-tests demonstrate that those higher in traditional values and behaviors had more positive attitudes toward seeking help (bicultural and traditional) than those with more assimilationist beliefs and behaviors (assimilationists and marginals). Holding on to at least part of traditional African American culture may allow individuals to tap into that resilient attitude that will use any means necessary to solve or cope with problems and rebound from setbacks.

#### *Limitations and Conclusion*

The findings of this study regarding the impact of economic factors, the benefits of rejecting cultural assimilation and the negative effect assimilation has on attitudes toward seeking mental health services for African Americans are compelling. Yet, they must be considered in light of the study's limitations.

As discussed, one of the primary limitations of the current study was the use of an abbreviated help-seeking measure rather than the full scale. While I was able to correct for attenuated results, this does not substitute for findings where all items of the IASMHS are included. Although I imagine that the pattern of results utilizing the full scale would be similar to those attained in the current study, to strengthen confidence in this conjecture, I propose two future studies: 1) a replication study to ascertain whether findings from the current study are maintained with use of the 11 items and 2) a validation study where findings from the current study are compared to one in which all 24 items from the IASMHS are assessed.

The unplanned abbreviated assessment of attitudes toward seeking mental health services presented some interesting challenges to the current study. Generally speaking, abbreviated scales rarely provide the same levels of reliability and validity as full scale measures. Given that abbreviated scales only utilize a sample of the available items, inter-item correlations and assessed relationships with external criterion suffer. These issues were considered when I performed analyses with items from the Inventory of Attitudes toward Seeking Mental Health Services. Though the planned analyses called for use of the full 24 item scale, the current study only assessed the first 11 of those items. Because I utilized fewer items, internal reliability and validity of findings were likely compromised. Statistical analyses allowed me to correct for the compromised reliability but could not correct for the missing item content. Though the 11 items (later reduced to ten) did not present an optimal reliability coefficient, it was not egregious at .62. Comparable reliability coefficients have been reported for the well validated and frequently utilized ATSPPH scale (Fischer & Turner, 1970). Because there is no well established body of literature for the IASMHS, findings from the current study must be compared to research utilizing this seminal help-seeking measure.

Analyses utilizing the ten items seemed to indicate that African Americans' attitudes toward seeking mental health services were moderately positive. This was somewhat surprising considering that the extant literature on African Americans' attitudes toward seeking help describes them as largely negative. However, using data from the National Comorbidity Study, Diala et al. (2000) found that prior to use of mental health services, African Americans had more positive attitudes than whites toward seeking care, but were less likely to use them. In following this rationale, it is possible that attitudes toward seeking mental health services were largely positive because many of the current study's participants may have never utilized mental health services. After utilization, Diala and colleagues (2000) found that African Americans' attitudes were less positive than those of whites. While this information was not collected within the current study, it provides a possible explanation for the differences in help seeking attitudes found across the literature.

Additionally, comparably positive levels of help-seeking attitudes among African American adults have been obtained in additional studies using the ATSPPH (Fischer &

Turner, 1970; Fischer & Farina, 1995) to measure the construct (i.e., Duncan, 2003). This is encouraging considering that the vast majority of questions from the IASMHS (17 out of 24) originated from the ATSPPH (McKenzie et al., 2004). Thus, despite using an abbreviated measure, it is likely findings of the current study provide an accurate reflection of the sample's magnitude and direction of their help-seeking attitudes. It is likely that the pattern of results achieved in the current study would be similar to those if the full scale had been assessed.

A drawback to using the abbreviated scale was my inability to assess for the IASMHS's three subscales as planned: psychological openness, help-seeking propensity, and indifference to stigma. Because only ten items were used for statistical analysis, the three calculated subscales did not provide enough reliability when those items were divided respectively. Because subscale correlations and full scale internal consistency were high in the validation study, McKenzie and colleagues (2004) indicated that their inventory could be used to conceptualize help-seeking either unidimensionally or according to the three specified dimensions. As such, the ten viable items were assessed as a unidimensional scale. By using all of the items and creating item parcels, I was able to estimate help-seeking attitudes unidimensionally with more observed indicators than what I would have with just the three subscale scores. Additionally, assessing the items on one dimension allowed for ease of comparison with existing help seeking measures, most of which are unidimensional.

In general, the item parcels provided adequate measure of help-seeking within the tested models and provided adequate model fit, even though one of the item parcels did not seem to perform as well as the other four. Parcel Five (see Figure 3.1) attained a significantly lower factor loading than the other parcels. Items used to calculate that parcel included: "If I were to experience psychological problems, I could get professional help if I wanted to" and "Important people in my life would think less of me if they were to find out that I was experiencing psychological problems." The first of these items had problems with skewness and kurtosis. This is likely the source of the problem with this parcel adequately loading in the measurement model.

An additional limitation to the study involved its methodology. A wide variety of assessment methodologies exist, including pencil-and-paper tests, computerized

assessments, projective techniques, interviews (both structured and unstructured), simulation exercises, etc. Use of self-report inventories may have limited the predictive validity of the findings in that surveys are considered, by some, as fallible research tools dependent upon participant honesty (Birnbaum, 2004). Though, surveys provide an efficient, convenient approach to collecting data that allow participants to reveal information they may not otherwise share with others. The survey protocol in the current study not only asked for demographic data from the respondents, but information on personal habits, opinions, attitudes, and feelings. Often it is difficult to even be honest with ourselves concerning some of these things. For example, admitting how acculturated the participant may or may not be into the dominant culture or how comfortable he or she is with mental illness could be very anxiety provoking. Even so, participants likely provided accurate reports of their attitudes and feelings given that their responses were anonymous. While African Americans in the current study generally seemed to have positive attitudes toward seeking mental health services, use of self report was unable to account for actual help-seeking behavior. A combination data collection approach may be more informative, one in which both self report and participant records are assessed and compared to increase our understanding of whether African American attitudes actually predict help-seeking behavior.

Despite these limitations, the current study makes several important contributions. First of all, results verify that economic factors are indeed important to African Americans' attitudes toward seeking mental health services. While assumed, the current study was able to provide empirical evidence of this highly theorized relationship. Though SES proved to be a stronger predictor, results also demonstrated the importance of culture. The current study has shown that African Americans' attitudes toward mental health services are indeed largely positive and affected by cultural values and beliefs. Once assumed to have negative attitudes toward mental health services across the board, the current study demonstrated that this is certainly not the case. In fact, help seeking attitudes seem to be in an active process of development and change among participants from ones of mistrust to openness. Diala and colleagues (2000) reiterate this sentiment, noting that African Americans were more likely than White Americans to report positive attitudes toward seeking professional help and to feel comfortable discussing personal

problems with a professional, and they were less embarrassed about friends knowing that they were seeking therapy prior to service use. Even more compelling was the finding that it may be more beneficial for African Americans to reject mainstream cultural values and beliefs. Those who do appear to be more open to alternative coping strategies, even seeking professional help.

The pattern of results yielded exciting findings and has strong implications for research and practice. Future research should continue to measure African American acculturation multidimensionally as a means to understand within-group variation in cultural worldviews, how cultural influences play a role in the development of coping responses, and how the complexities of cultural orientation relate to various mental health outcomes/functioning. Additionally, research should continue testing models of help seeking for African Americans. One primary model was proposed here, but in order for more rigorous testing, opposing models encompassing alternative constructs of importance should be compared to the target model.

In regards to practice, research has shown attitudes toward seeking mental health services to be highly predictive of individuals' use of services (Cash, Kehr, & Salzbach, 1978; Fischer & Farina, 1995), entirely unrelated to service utilization (Leaf et al., 1988; Lefebvre, Lesage, Cyr, Toupin, & Fournier, 1998), and predictive only under certain circumstances (Leaf, Livingston, & Tischler, 1986). This lack of consistent findings applies doubly so for African Americans, particularly when taking into consideration whether or not attitudes were assessed before or after having a therapy experience. Diala (2000) suggests that African Americans often have positive attitudes toward mental health services prior to entering psychotherapy, much like the current study. However, those attitudes take a sharp decline after the first session and many do not return to get the professional help they may need. Thus, if services are to be maximally effective for this community, research should continue to investigate methods of retaining African Americans' initially positive attitudes. In order to build on this important development, the next step might be to address the issues of who African Americans seek help from and what factors are important to maintaining therapeutic consistency, among others, so that help is maximally beneficial. These questions are important to answer in order to bring African Americans to services and ensure that these services are effective. Attitudes

toward seeking mental health services are influenced by a complex relationship between the individual and his or her context. While the current study has tapped into a portion of this complexity, much is left to be uncovered.

## APPENDIX A

Dear Participant,

You are invited to participate in a project evaluating the impact of various life factors on attitudes toward seeking mental health services. The project is sponsored by the Clinical Psychology Program at the University of Kentucky. This research will contribute to our understanding of help seeking attitudes within the African American community. Your input is very important.

The survey consists of approximately 150 multiple choice questions that will take less than 30 minutes to complete. Upon completion, you will have the opportunity to win 1 of 3 \$100 gift cards to Target or Walmart (your choice). Questions are related to culture, religion, stigma of mental illness, and how these feelings impact our attitudes toward mental health services. Some of these questions are personal, but please be assured that your responses will be compiled anonymously and the results will be used to develop our understanding of how to bring African Americans in need to quality, effective mental health services.

Your participation is anonymous and completely voluntary. By logging in to the survey, you are indicating an understanding that participation is voluntary and anonymous. No information that could identify you will be connected with your responses. Only when you have completed the survey will you be directed to a separate site to provide your name and email address to be entered into the prize drawing. For this reason, I ask that you please only complete the survey *once*. If you have any questions about this questionnaire or the research project, you may contact me at 214-734-6075 or at [amsmitc@uky.edu](mailto:amsmitc@uky.edu).

This project has been approved by the University of Kentucky Institutional Review Board (IRB), Human Subjects Committee which oversees all scientific studies that involve people. If you would like additional information about this approval, please contact \_\_\_\_\_, IRB Coordinator at ### ## ## or at \_\_\_\_\_@uky.edu.

Thank you very much for your participation.

Sincerely,

Andrea M. Smith, M.S.  
Doctoral Candidate  
University of Kentucky  
Department of Psychology



APPENDIX B

K6 questionnaire for assessing non-specific distress

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

<b>Q1. During the past 30 days, about how often did you feel ...</b>	<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
a. ...nervous?	1	2	3	4	5
b. ...hopeless?	1	2	3	4	5
c. ...restless or fidgety?	1	2	3	4	5
d. ...so depressed that nothing could cheer you up?	1	2	3	4	5
e. ...that everything was an effort?	1	2	3	4	5
f. ...worthless?	1	2	3	4	5

**Q2.** The last six questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur More often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, circle response option “4.”)

**The next few questions are about how these feelings may have affected you in the past 30 days. You need not answer these questions if you answered “None of the time” to all of the six questions about your feelings.**

**Q3.** During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings? \_\_\_\_ (# of days)

**Q4. Not counting the days you reported in response to Q3,** how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings? \_\_\_\_ (# of days)

**Q5.** During the past 30 days, how many times did you see a doctor or other health professional about these feelings? \_\_\_\_ (# of times)

**Q6.** During the past 30 days, how often have physical health problems been the main cause of these feelings?

<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
------------------------	-------------------------	-------------------------	-----------------------------	-------------------------

1                      2                      3                      4                      5

Which of the following could best explain the source of your distress described above?  
(Please select only 1 option)

1. Physical health problems
2. Interpersonal difficulties (marital problems, problems with interpersonal relationships in general, etc.)
3. Emotional adjustment problems (feeling down or depressed, having self-doubt, feeling anxious or worried, etc.)
4. Death of a loved one
5. Economic difficulties
6. I have not experienced any distress

## APPENDIX C

### Cultural Mistrust Inventory

- 1) \*Whites are usually fair to all people regardless of race. **BW**
- 2) White teachers teach subjects so that they favor whites. **ET**
- 3) White teachers are more likely to slant the subject matter to make blacks look inferior. **ET**
- 4) White teachers deliberately ask black students questions which are difficult so they will fail. **ET**
- 5) There is no need for a black person to work hard to get ahead financially because whites will take what  
you earn anyway. **BW**
- 6) \*Black citizens can rely on white lawyers to defend them to the best of their ability. **PL**
- 7) Black parents should teach their children not to trust white teachers. **ET**
- 8) White politicians will promise blacks a lot but deliver little. **PL**
- 9) White policemen will slant a story to make blacks appear guilty. **PL**
- 10) \*White politicians usually can be relied on to keep the promises they make to blacks. **PL**
- 11) Blacks should be suspicious of a white person who tries to be friendly. **IR**
- 12) \*Whether you should trust a person or not is not based on his race. **IR**
- 13) Probably the biggest reason whites want to be friendly with blacks is so they can take advantage of  
them. **BW**
- 14) \*A black person can usually trust his or her white co-workers. **BW**
- 15) If a white person is honest in dealing with blacks, it is because of fear of being caught. **BW**
- 16) A black person cannot trust a white judge to evaluate him or her fairly. **PL**
- 17) \*A black person can feel comfortable making a deal with a white person simply by a handshake. **BW**
- 18) Whites deliberately pass laws designed to block the progress of blacks. **PL**
- 19) \*There are some whites who are trustworthy enough to have as close friends. **IR**
- 20) Blacks should not have anything to do with whites since they cannot be trusted. **IR**
- 21) It is best for blacks to be on their guard when among whites **IR**
- 22) Of all ethnic groups, whites are really the Indian-givers. **IR**
- 23) \*White friends are least likely to break their promise. **IR**
- 24) Blacks should be cautious about what they say in the presence of whites since whites will try  
to use it against them. **IR**
- 25) Whites can rarely be counted on to do what they say. **IR**
- 26) \*Whites are usually honest with blacks. **IR**
- 27) \*Whites are as trustworthy as members of any other ethnic group. **IR**
- 28) Whites will say one thing and do another. **IR**
- 29) White politicians will take advantage of blacks every chance they get. **PL**
- 30) When a white teacher asks a black student a question, it is usually to get information that can  
be used  
against him or her. **ET**
- 31) \*White policemen can be relied on to exert an effort to apprehend those who commit crimes  
against  
blacks. **PL**
- 32) \*Black students can talk to a white teacher in confidence without fear that the teacher will  
use it against him or her later. **ET**
- 33) \*Whites will usually keep their word. **IR**
- 34) \*White policemen usually do not try to trick blacks into admitting they committed a crime

- that they did not do. *PL*
- 35) \*There is no need for blacks to be more cautious with white businessmen than with anyone else. *BW*
- 36) \*There are some white businessmen who are honest in business transactions with blacks. *BW*
- 37) White storeowners, salesmen, and other white businessmen tend to cheat blacks whenever they can.  
*BW*
- 38) Since whites can't be trusted in business, the old saying "one in the hand is worth two in the bush" is a good policy to follow. *BW*
- 39) Whites who establish businesses in black communities do so only so that they can take advantage of blacks. *BW*
- 40) White politicians have often deceived blacks. *PL*
- 41) \*White politicians are equally honest with blacks and whites. *PL*
- 42) Blacks should not confide in whites because they will use it against you. *IR*
- 43) \*A black person can loan money to a white person and feel confident it will be repaid. *BW*
- 44) \*White businessmen usually will not try to cheat blacks. *BW*
- 45) White business executives will steal the ideas of their black employees. *BW*
- 46) A promise from a white is about as good as a three dollar bill. *BW*
- 47) Blacks should be suspicious of advice given by white politicians. *PL*
- 48) \*If a black student tries, he will get the grade he deserves from a white teacher. *ET*

\*Items are reverse-scored; PL: Politics and Law subscale; ET: Education and Training subscale; BW: Business and Work subscale; IR: Interpersonal relations subscale

## APPENDIX D

### Perceived Discrimination-Devaluation Scale

1= Strongly Agree, 6 = Strongly Disagree

1. Most people would willingly accept a former mental patient as a close friend.
2. Most people believe that a person who has been in a mental hospital is just as intelligent as the average person.
3. Most people believe that a former mental patient is just as trustworthy as the average citizen.
4. Most people would accept a fully recovered mental patient as a teacher of young children in a public school
5. Most people believe that entering a mental hospital is a sign of personal failure (R).
6. Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time (R).
7. Most people think less of a person who has been in a mental hospital (R).
8. Most employers will hire a former mental patient if he or she is qualified for the job.
9. Most employers will pass over the application of a former mental patient in favor of another applicant (R).
10. Most people in my community would treat a former mental patient as they would treat anyone.
11. Most young women would be reluctant to date someone who has been hospitalized for a serious mental disorder (R).
12. Once they know a person was in a mental hospital, most people will take his or her opinions less seriously (R).

## APPENDIX E

### Religious Commitment Inventory

1. I often read books and magazines about my faith.
2. I make financial contributions to my religious organization.
3. I spend time trying to grow in understanding of my faith.
4. Religion is especially important to me because it answers many questions about the meaning of life.
5. My religious beliefs lie behind my whole approach to life.
6. I enjoy spending time with others of my religious affiliation.
7. Religious beliefs influence all my dealings in life.
8. It is important to me to spend periods of time in private religious thought and reflection.
9. I enjoy working in the activities of my religious organization.
10. I keep well informed about my local religious group and have some influence in its decisions.

## APPENDIX F

### Multidimensional Acculturation Scale for People of African Descent

Identify the response that best reflects your agreement/disagreement to each item

1= Strongly Disagree 2= Disagree 3=Slightly Disagree

4=Slightly Agree 5= Agree 6= Strongly Agree

1. I take a great deal of pride in being a person of African ancestry (African, African American, Black Cuban, Black Brazilian, Trinidadian, Jamaican, etc.)
2. If I have children, I will give them an African naming ceremony.
3. I do not feel connected to my African heritage.
4. If I have children, I will raise them to be American first and a person of African ancestry second.
5. I was raised to maintain cultural practices that are consistent with people of African descent.
6. I have difficulty accepting ideas held by the Black community.
7. I tend to generate friendships with people from different racial and cultural backgrounds.
8. I was socialized to treat my elders with respect.
9. Everyone has an equal opportunity to be financially successful in this country.
10. I am comfortable putting on the mask in order to fit in.
11. Despite facing potential discrimination, it is important for me to maintain my cultural beliefs.
12. I have in ways that are consistent with people of African ancestry even if other cultural groups do not accept it.
13. The way that I behave in public (work, school, etc.) is different than how I behave at home.
14. I consider myself to be a spiritual person.
15. I do not take things from the Earth without giving back to it.
16. I consider myself to be a religious (Christian, Catholic, Muslim, etc.) person.
17. It is vital for me to be actively involved in the Black community.
18. The word, "communalistic" describes how I interact with other people.
19. I prefer to be around people that are not Black.
20. I participate in many social events where few Blacks are in attendance.
21. I actively support Black owned businesses.
22. People should modify many of their values to fit those of their surroundings.
23. I express different cultural values in order to fit in.
24. I was socialized to support Black owned businesses.
25. My beliefs are largely shaped by my religion (Christianity, Catholicism, Islam, etc.)
26. Most of my closest friends and past romantic partners are from a variety of different cultural groups.
27. I prefer entertainment (movies, music, plays, etc.) that highlights Black talent.
28. I buy products that are made by people of African ancestry.
29. I do not purchase products from Black owned businesses.
30. I believe festivals maintain spiritual and physical balance in my community.
31. I perform various rituals for my departed ancestors.
32. I see no problem assimilating into other cultural values in order to be financially successful.

33. People of African descent should know about their rich history that began with the birth of humanity
34. I am actively involved in an African spiritual system.
35. Verbal agreements do not mean as much to me as written contracts do.
36. I do not own products that were made by people of African descent.
37. I use words from an African language when participating in by spiritual practices.
38. People in America should only speak English.
39. I will probably marry someone that is not Black.
40. Members of my culture should have an appreciation for African art and music.
41. My individual success is more important than the overall success of the Black community.
42. I expose myself to various forms of media (television, magazines, newspapers, internet, etc.) in order to keep up with current events that impact my community.
43. Blacks should not obtain reparations for being descendents of enslaved Africans since we are all reaping the benefits of slavery today.
44. I choose not to speak out against the injustices that impact people of African descent.
45. In embracing my culture, I can also recognize the dignity and humanity of other cultural groups.



## APPENDIX G

### Informal Help/ Self Reliance

Which of the following types of help would you ever see about problems with your emotions or other mental health concerns. Which would you seek first? Second? And so forth? Please rank order from 1 to 12, 1 being your first choice, 12 being your last.

1. psychiatrist
2. general practitioner or family doctor
3. any other medical doctor, like a cardiologist or(women: gynecologist / men: urologist)
4. psychologist
5. social worker
6. counselor
7. any other mental health professional, such as a psychotherapist or mental health nurse
8. a nurse, occupational therapist, or other health professional
9. a religious or spiritual advisor like a minister, priest, or rabbi
10. any other healer, like an herbalist, chiropractor, or spiritualist
11. a spouse, partner, or family member
12. take care of it yourself, wait for improvement

**APPENDIX H**  
**The Barratt Simplified Measure of Social Status (BSMSS)**

*Mark the appropriate box for your Mother's, your Father's, your Spouse / Partner's, and your level of school completed and occupation. If you grew up in a single parent home, mark only the score from your one parent. If you are neither married nor partnered circle only your score. If you are a full time student mark only the scores for your parents.*

Level of School Completed	Mother	Father	Spouse	Self
Less than 7th grade	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Junior high/ Middle school (9th grade)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partial high school (10th or 11th grade)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High school graduate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partial college (at least one year)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
College education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Graduate degree (Master's, Ph.D., J.D., etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Mark the appropriate number for your Mother's, your Father's, your Spouse / Partner's, and your occupation. If you grew up in a single parent home, use only the score from your parent. If you are not married or partnered mark only your score. If you are still a full-time student only mark the scores for your parents. If you are retired use your most recent occupation.*

Occupation	Mother	Father	Spouse	Self
Day laborer, janitor, house cleaner, farm worker, food counter sales, food preparation worker, busboy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Garbage collector, short-order cook, cab driver, shoe sales, assembly line workers, masons, baggage porter.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painter, skilled construction trade, sales clerk, truck driver, cook, sales counter or general office clerk.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Automobile mechanic, typist, locksmith, farmer, carpenter, receptionist, construction laborer, hairdresser.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Machinist, musician, bookkeeper, secretary, insurance sales, cabinet maker, personnel specialist, welder.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supervisor, librarian, aircraft mechanic, artist and artisan, electrician, administrator, military enlisted personnel, buyer.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nurse, skilled technician, medical technician, counselor, manager, police and fire personnel, financial manager, physical, occupational, speech therapist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mechanical, nuclear, and electrical engineer, educational administrator, veterinarian, military officer, elementary, high school and special education teacher,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physician, attorney, professor, chemical and aerospace engineer, judge, CEO, senior manager, public official, psychologist, pharmacist, accountant.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did you grow up with both parents?       Yes     No

If you grew up with one parent, which one was your primary caretaker?  Mother    Father    Other \_\_\_\_\_

Are you married or partnered?       Yes     No

Are you a full time student?       Yes     No

Do you live alone?       Yes     No

## APPENDIX I

### Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

The term professional refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term psychological problems refers to reasons one might visit a professional. Similar terms include mental health concerns, emotional problems, mental troubles, and personal difficulties. For each item, indicate whether you disagree (0), somewhat disagree (1), are undecided (2), somewhat agree (3), or agree (4):

#### **Items Administered**

1. There are certain problems which should not be discussed outside of one's immediate family.
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.
6. Having been mentally ill carries with it a burden of shame.
7. It is probably best not to know everything about oneself.
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.
9. People should work out their own problems; getting professional help should be a last resort.
10. If I were to experience psychological problems, I could get professional help if I wanted to.
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

#### **Items not administered**

12. Psychological problems, like many things, tend to work out by themselves.
13. It would be relatively easy for me to find the time to see a professional for psychological problems.
14. There are experiences in my life I would not discuss I would want to get professional help if I were worried or upset for a long period of time.

15. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.
16. Having been diagnosed with a mental disorder is a blot on a person's life.
17. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.
18. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.
19. I would feel uneasy going to a professional because of what some people would think.
20. People with strong characters can get over psychological problems by themselves and would have little need for professional help.
21. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
22. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."
23. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

## APPENDIX J

### Email Solicitation for Online Participants

Hello Friends and Family,

I need your help! You are invited to participate in my dissertation study investigating African American's attitudes toward seeking mental health services. I would love if you would take my online survey. It will take just 30 short minutes of your time, and upon completion, you'll be eligible to enter the drawing for gift cards to Target or Walmart!  
*Please go to*

<http://smithdissertation.9f.com>

as soon as possible to read more about the study and to complete the survey if you have not already done so. And if there are other African Americans aged 18 and over that you think would be willing to do the survey, please forward this link to them as well. Thank you so much for your help!

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## ANDREA M. SMITH

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### EDUCATION

University of Kentucky. Lexington, Kentucky  
Major: Clinical Psychology  
Status: Doctoral Candidate  
Expected Graduation: Summer 2009

University of Kentucky. Lexington, Kentucky  
Major: Clinical Psychology  
Thesis: Differentiating ethnic identity and acculturation in predicting African American psychosocial functioning  
Chair: Tamara L. Brown  
Degree: Master of Science May 2006

Florida Agricultural & Mechanical University, Tallahassee, Florida  
Major: Psychology  
Minor: Computer Information Systems  
Degree: Bachelor of Science, Summa Cum Laude May 2003

### RESEARCH INTERESTS

- Formulating culturally sensitive psychological treatments for African Americans
- Exploring the role of cultural variables in mental health, including ethnic identity and acculturation

### PROFESSIONAL EXPERIENCES

#### *Research*

Predoctoral Intern September 2008- Present  
Federal Medical Center, Carswell  
Fort Worth, TX  
(Forensics & Substance Abuse)

Graduate Research Assistant August 2003 – Present  
Department of Psychology  
University of Kentucky  
(Minority Mental Health)  
PI: Tamara L. Brown, Ph.D.

Ronald E. McNair Postbaccalaureate Achievement Program Summer 2002  
TRIO Programs, Florida A&M University, Tallahassee, FL  
(Self Esteem)  
P.I: Dana Dennard, Ph.D.

#### *Clinical*

Practicum Therapist August 2007 – May 2008  
Federal Medical Center, Women's Prison Camp  
Lexington, KY

- Groups: Anger Control, Effective Communication and Assertiveness, Trauma Workshop

Financial Coordinator July 2007 – August 2008  
 Jesse G. Harris Jr. Psychological Services Center  
 Department of Psychology  
 University of Kentucky

Practicum Therapist August 2006-July 2007  
 Chrysalis House for Substance Abusing Women  
 Lexington, Kentucky  
 ▪ Groups: Corrective Thinking (CBT)

Practicum Therapist August 2005-August 2006  
 Counseling & Testing Center  
 University of Kentucky

Therapist August 2004 – August 2008  
 Jesse G. Harris Jr. Psychological Services Center  
 Department of Psychology  
 University of Kentucky

Social Skills Group Co-Leader Spring 2005, Spring 2006  
 (Ages 10-13)  
 Jesse G. Harris Jr. Psychological Services Center  
 Department of Psychology  
 University of Kentucky

### *Conferences Attended*

Compact for Faculty Diversity Annual Institute on Teaching and Mentoring, 2004 - 2006  
 ▪ Attended as a Doctoral Scholar

Compact for Faculty Diversity Annual Institute on Teaching and Mentoring, Doubletree Hotel, Arlington, VA, October 2002

- Selected by the Southern Regional Education Board as one of fifty McNair Scholars invited to attend nationwide
- First McNair Scholar from Florida A&M University ever invited to attend
- Gained the unique opportunity to network and learn from a forum of minority PhD candidates and recipients

### *Conference presentations*

Brown, T.L., Phillips, C.M., **Smith, A.M.**, & Abdullah, T. (2007, July). Investigating the role of culture in mental health: A research agenda for the future. Oral presentation at Association of Black Psychologists International Convention, Houston, TX.

**Smith, A.M.** & Brown, T.L. (2007, April). Connecting ethnic identity, religiousness, and substance use among African Americans. Paper presented at the University of Kentucky Graduate School Interdisciplinary Conference, Lexington, KY.

**Smith, A.M., & Brown, T.L.** (2007, February). Connecting ethnic identity, religiousness, and substance use among African Americans: A pilot study. Paper presented at the Kentucky Psychological Association Spring Conference, Lexington, KY.

**Smith, A.M., & Brown, T.L.** (2006, August). Differentiating African American ethnic identity and acculturation. Paper presented at the American Psychological Association Convention, New Orleans, LA.

**Smith, A.M., & Brown, T.L.** (2006, July). Differentiating ethnic identity and acculturation in African Americans. Paper presented at the Association of Black Psychologists International Convention, Cleveland, OH.

Acevedo-Polakovich, I. D., Brown, T. L., **Smith, A. M.**, Grayson, L. M., & Jernigan T. E. (2004, November). The study of collectivism in African Americans and European Americans: Recent trends and future directions. Paper presented at the Notre Dame Conference on Culture and Diversity, South Bend, IN.

**Smith, A. M.** (2002, July). Relationship of number of siblings and self esteem. Paper presented at the SAEOPP/McNair Scholars Research Conference, University of Tennessee at Knoxville, Knoxville, TN.

- Oral presentation awarded 2<sup>nd</sup> place in the Social Science division

#### *Invited Symposia*

**Smith, A. M.** (2008, March) Clinical colloquium conducted for psychology undergraduate psychology majors at the University of Kentucky, Lexington, KY.

**Smith, A.M.** (2005, November) Departmental colloquium conducted for University of Kentucky's Clinical Psychology Program, Lexington, KY.

**Smith, A.M.** (2005, November) Departmental colloquium conducted for University of Kentucky's Social Psychology Program, Lexington, KY.

**Smith, A.M.,** Bailey, U.L. (2005, March). *Graduate Programs in Psychology*. Symposium conducted at the 2005 panel for Kentucky State University's Behavior Social Sciences Club, Frankfort, KY.

#### *Publications*

**Smith, A.M.,** Phillips, C.M., & Brown, T.L. (2008). Ethnic identity, religiousness, and drinking among African Americans: What's the connection? *Journal of Ethnicity in Substance Abuse*, 7(4), 465-479.

Brown, T.L., Acevedo-Polachovich, I.D., & **Smith, A.M.** (2006). Multicultural Supervision Concerns in Counseling Ethnic Minority Children and Families. In T. K. Neill (Ed) *Helping Others Help Children: Clinical Supervision of Child Psychotherapy*. Washington, DC: APA Press.

**Smith, A. M.** & Dennard, D.O. (2002). Relationship of number of siblings and self

esteem in black college students. Florida A&M University McNair Journal, 12(1), 40-42.

*Submitted Manuscripts*

**Smith, A.M.**, & Brown, T.L. The culture connection: Defining a pathway to mental health care for African Americans (submitted to *Clinical Psychology Review*)

**Smith, A.M.**, Acevedo-Polachovich, I.D., & Brown, T.L., The structure of ethnic identity in African Americans and European American college students. (submitted to *Journal of Black Psychology*)

*Manuscripts Being Prepared For Submission*

Brown, T.L., Acevedo-Polachovich, I.D., & **Smith, A.M.**, African American collectivism: The importance of social context and measure content.

**Smith, A. M.**, Differentiating Acculturation and Ethnic Identity: Predicting African American Mental Health.

*Teaching/Mentoring Experience*

Graduate Student Mentor Summer 2006  
Kentucky Young Scientist Summer (KYSS)  
Research Program for Undergraduate Students  
University of Kentucky

Teaching Assistant August 2004 – May 2005  
Department of Psychology  
University of Kentucky  
(PSY 216, Applications of Statistics in Psychology)

**HONORS AND AFFILIATIONS**

*Honors*

Student Research Support Award Summer 2006, Summer 2007  
University of Kentucky Graduate School

Research Travel Award Spring 2006, Summer 2007  
University of Kentucky Psychology Department

Graduate Student Enrichment and Research Award February 2005  
University of Kentucky African American Studies and Research Program

Southern Regional Education Board Doctoral Scholar August 2004-Present

Lyman T. Johnson Academic Year Fellowship August 2003

Ronald E. McNair Scholar Summer 2002

Florida A&M University Presidential Scholar 2000 - 2003

National Dean's List

2000 – 2003

National Achievement Scholar  
2000

*Affiliations*

American Psychological Association  
Graduate Student Affiliate

Society for the Psychological Study of Ethnic Minority Issues (APA div. 45)  
Student Member

Kentucky Psychological Association  
Graduate Student Affiliate

Association of Black Psychologists  
Graduate Student Affiliate

National Alliance for Mental Illness  
Multicultural Action Center, African American Leaders Group

Black Graduate and Professional Student Association

Psi Chi National Honor Society in Psychology  
Former Florida A&M University Chapter President